The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

Editorial and Secretarial Offices:
280 Bloor St. West, Toronto 5, Ont.

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September 1959, Volume 36, No. 9

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Notes About People

Nurse Appointed to O.H.S.C.

F. Louise Jamieson, R.N., B.A., former assistant registrar of the Registered Nurses' Association of Ontario, has been appointed to the staff of the Ontario Hospital Services Commission as a consultant

F. Louise Jamieson

in nursing services. Miss Jamieson has just completed a year's special study at the University of Toronto where she received a certificate in hospital nursing service administration.

A graduate of Wellesley Hospital School of Nursing, she also holds a certificate in nursing education and a B.A. from the University of Toronto, and a certificate in psychiatric nursing from the University of Western Ontario.

She has done general and private duty nursing and was a clinical instructor and supervisor at the Kitchener-Waterloo Hospital, Kitchener, Ont. Miss Jamieson has also been assistant director of nursing at the Toronto Western Hospital. As nurse educator with the Colombo Plan she was in India, and during the second world war served with the South African Military Nursing Service in Italy and South Africa.

Also Appointed to Ontario Commission

The Ontario Hospital Services Commission now has a personnel officer and consultant. He is Charles W. Couch, who goes to the commission from the Hydro Electric Power Commission of Ontario where he has worked since 1948.

Born and educated in Campbellford, Mr. Couch studied at the University of Toronto and Queen's University, Kingston, and in 1948 received a diploma in industrial relations.

Stanley R. P. Montgomery, M.D.

Dr. Stanley R. P. Montgomery, psychiatrist with the Ontario Department of Health for 31 years, died on July 27 after a brief illness in Lindsay, Ontario. He was 61.

Dr. Montgomery, born in Toronto, graduated in medicine from the University of Toronto in 1923, and did postgraduate work in tropical diseases in London, England. He served as a medical missionary in Southern Rhodesia for several years before returning to Canada.

He began his psychiatric work for the department at the Whitby Hospital. In 1939 he went to St. Thomas as assistant superintendent of the Ontario Hospital there. Two years later he became superintendent of the Ontario Hospital, Toronto. In 1949 he was appointed superintendent of the Ontario Hospital School in Orillia, and in 1951 became director of the Child Guidance Clinic, at the East York-Leaside Health Clinic in Toronto, Ont.

Appointed to U. of Sask.

C. A. Meilicke, former administrative resident at the University Hospital in Saskatoon, Sask., has been named supervisor of correspondence work in hospital administration and instructor in commerce at the University of Saskatchewan. In this post Mr. Meilicke will be responsible for planning and organizing an extension course in hospital administration for the managerial personnel of small hospitals. He will also direct the course when it begins in the fall of 1960.

Born in Regina, Sask., Mr. Meilicke was educated in Prince Albert and Saskatoon, where he received a bachelor of commerce degree from the University of Saskatchewan, and has attended the course in hospital administration at the University of Toronto.

Officers of International Hospital Federation Elected

New president of the International Hospital Federation is Dr. Romain de Cock. Dr. de Cock, who is a surgeon and president of the Belgian Hospital Association, has been vice-president of the I.H.F. since 1955, and will hold office as president for four years.

Appointed first vice-president was Dr. E. L. Crosby, director of the American Hospital Association. E. F. Collingwood, chairman of the Newcastle Regional Hospital Board in England; and E. J. Faucon, secretary-general of the French Hospital Federation and of the Léon Bérard Cancer Centre at Lyon, were also elected vice-presidents.

On U. of T. Hospital Administration Staff

Hugh McGann, who has been an inspector in the Hospital Consultation and Inspection Division of the British Columbia Hospital Insurance Service, takes up new duties as assistant professor in the department of Hospital Administration, School of Hygiene, University of Toronto, this month. Mr. McGann first joined B.C.H.I.S. in 1957 after completing his residency at the University of Alberta Hospital in Edmonton, Alta., taken in conjunction with his course in hospital administration at the University of Toronto.

Henry C. J. Simkins, R.T.

Henry C. J. Simkins, a pioneer x-ray technician in Quebec, died in Montreal on July 7.

Mr. Simkins was born in England where he worked as an x-ray technician under the late Dr. A. H. Pirie whom he accompanied to Canada to work at the Royal Victoria Hospital, Montreal, Que., in 1912. Mr. Simkins had been with the Royal Victoria Hospital for more than 47 years.

Changes in St. Ann's Order, in B.C.

Sister Superior Mary Angelus, for the past six years administrator of St. Joseph's Hospital, Victoria, B.C., has been made provincial superior of the Sisterhood of St. Ann. She succeeds Sister Mary Luca who goes as administrator to St. Ann's Hospital in Juneau, Alaska. New administra-

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tor for St. Joseph's is Sister Mary Anne Celesta who has been 16 years in the hospital's business office, and last year was administrator of St. Martin's Hospital at Oliver, B.C.

At Morden, Man.

George W. Swan is now administrator of the District General Hospital at Morden, Man. Mr. Swan was formerly personnel officer at the Regina General Hospital, Regina, Sask., the hospital where he had been employed since 1940. In 1955 he completed the extension course in hospital organization and management conducted by the Canadian Hospital Association.

At New Burlington Hospital

William O'Neill, formerly assistant administrator of St. Paul's Hospital, Saskatoon, Sask., has been appointed administrator of the new 245-bed Joseph Brant Memorial Hospital in Burlington, Ont.

Born in Dundee, Scotland, Mr. O'Neill was educated at the University of London. Before coming to Canada five years ago, he served as senior administrative officer at the South West Durham Hospital in England. He has also been a director of the Saskachewan Hospital Association.

William O'Neill

Appointed at School of Hygiene, U. of T.

Dr. John R. Brown has been appointed professor and head of the department of physiological hygiene in the School of Hygiene, University of Toronto.

Dr. Brown leaves his post as lecturer in applied physiology at the London School of Hygiene and Tropical Medicine, University of London, England, and will be responsible for developing the University of Toronto's recently re-organized program of post-graduate teaching for industrial and public health physicians. The course will prepare physicians for the university's Diploma in Industrial Health and can be taken full-time over one academic year or part-time over two years.

• After 45 years as superintendent of the United Church's R. W. Large Memorial Hospital at Bella Bella, B.C., Dr. George Darby has retired.

• J. W. Short, a 1957 graduate of the University of Toronto's course in hospital administration,

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People
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has been appointed assistant administrator at the Sarnia General Hospital, Sarnia, Ont. Mr. Short has been administrative assistant at the Royal Jubilee Hospital, Victoria, B.C. for the past two years.

• Dr. Guillaume Gill, director of the department of radiology at the Hôtel Dieu de Sorel, Sorel, Que., has received a Fellowship from the American College of Radiology. Dr. Gill is the second French-Canadian to be awarded this honour.

• Dr. C. Lafrance is now president of the medical staff at St. Coeur de Marie Hospital, Hawkesbury, Ont.

• W. S. Baldwin, formerly administrator of the Moose Factory Indian Hospital in Moose Factory, Ont., has been transferred to the Lady Wellington Indian Hospital in Oshweken, Ont.

• Dr. Kenneth T. MacFarland has been appointed obstetrician and gynaecologist-in-chief of the Montreal General Hospital, Montreal, Que. He succeeds Dr. Clifford V. Ward who has been promoted to the consulting staff.

• Dr. Louis-Philippe Leclerc has been named a member of l'Association Française de Chirurgie de Paris. He is one of only five Canadians who are members. Dr. Leclerc is surgeon at the L'Hôpital du St-Sacrement in Quebec, Que.

• Miss D. Dubois, for 13 years at the Wynyard Union Hospital, Wynyard, Sask., has left her post as administrator there to join the Department of Public Health in Saskatchewan as nurse in charge of the out-post hospital at Sandy Bay in Northern Saskatchewan.

• J. H. Williams has recently been appointed business manager at Kemptville District Hospital, Kemptville, Ont.

Research Endowment Appeal

A memorial fund for research is to be set up in honour of the late Dr. William Cone. Dr. Wilder Penfield, co-founder and director of the Montreal Neurological Institute announced recently that the nucleus of the fund will be the $70,000 Cone Research Fund, built up over the years by Dr. Cone himself from gifts received from his patients. "Every leading nation should have at least one permanent institute such as the Montreal Neurological," said Dr. Penfield in speaking about the importance of maintaining such a research fund. "Man and his mind is our problem," he said, and went on to point out that an appeal for support to private sources and industry should be made to help in establishing the fund.

A Sad Mistake

We have fluffed. During some process of production of the July issue a key word was omitted from "Notice the Need to be Noticed", by William Line. On page 33 of the July 1959 issue Professor Line's second sentence should read: "I do *not* like the idea of utilization of staff" (*not*, repeat *not*). We are especially sorry because we do not like it either.

Our apologies to Dr. Line. We hope that our readers did not miss the point of the article because of this deplorable omission.—*Editorial Staff.*

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Don't give fire a place to start

THE week of October 4th to 10th has been slated as fire prevention week for 1959, with the slogan "Don't give Fire a Place to Start". This tag is a challenging one because by far the best emergency program is one you never actually have to use. To reach this height of safety, all possible hazards must be eliminated and every employee must be on the alert.

It has been said that safety begins at the drafting board and this should be true of all new plants; but many hospitals have units still in use which are not of fire-resistant construction. Moreover any building is just as fire-resistant as its contents. Perhaps no other type of building has so many possible hazards and nowhere else do you find large numbers of people quite unable to help themselves in case of emergency. Day-to-day care must therefore be taken to prevent emergencies.

Most authorities agree that each hospital should appoint a fire warden and in many cases this is the chief engineer. This officer should make regular rounds of the plant to check the safety of electrical appliances, wiring, and the storage of inflammable gases or liquids. There must be no nests of waste material left anywhere—for reasons of safety as well as sanitation. Since every department is this officer's beat, he must necessarily be a tactful person —a friend of every department head. He, too, must be prompt to make suggestions: Have the new curtains in the auditorium been flame-proofed? Should fire retardant paint be used in a given area? Are the Christmas decorations safe? Are there plenty of ash trays where smoking is permitted? Cigarettes are a hazard but the surreptitious drag is more dangerous than a smoke in the proper place.

But safety from fire must also be the responsibility of everyone who works in the hospital. Only the nurse, for instance, can make sure that a patient in an oxygen tent has no smoking materials in there with him. Frequent lectures for all categories of staff are helpful, together with instruction and constant watchfulness on the part of department heads. Doctors should in all ways set a good example. Finally, can everybody, down to the newest sweeper, *read* posters put up for their information? It may be that these should appear in at least four languages. May we suggest that you take fire prevention week seriously and do a double check in an effort to eliminate every possible fire hazard.—*J.F.*

Legislation should encourage O.P. services

THE British North America Act, Section 92 (7) states that the provision of hospital care is a provincial responsibility. Bill 320 sets forth the general principles for a national hospital insurance program and permits each province to work out the details of its own plan within this framework. Thus, in Canada, we have a variety of provincial programs and this variety is reflected especially in the provision of out-patient services. This ranges from almost complete coverage in Nova Scotia to almost no coverage in Alberta. Yet, despite these individual variations, all provincial plans operate within the framework of the federal regulation. Section 7 (3) (j) of the regulations under the Hospital Insurance and Diagnostic Services Act provides that gross earnings accruing to the hospital for the provision of out-patient services, less certain allowances, must be deducted from the estimates of expenditures which form the basis of calculating the per diem rate. Under existing accounting practices such gross earnings would include charges for services provided to indigents and other persons whose accounts must eventually be classified as "free work" or uncollectable. Therefore the strict application of this regulation will result in a loss to

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the hospital since the estimated amount of "free work" which must be included in the budget for the following year reduces the per diem rate.

It has been stated that the three main functions of the out-patient department are the care of the sick, the protection of community health, and education. Future planning for out-patient services by hospital administration should be in accordance with these three main functions and worked out in co-operation with the medical profession. Provincial legislation for out-patients' services should be so formulated that it assists and encourages this type of service.

It is important that those who formulate legislation be thoroughly aware of the needs of the medical profession, the hospitals, and the community served. Although financial considerations are necessary to a sound government fiscal policy, the philosophy of meeting the patient's needs still constitutes the basis for the kind of legislation desired by everyone in the health field.

In addition, we feel that in any province with a hospital care insurance plan, more effective use of hospital beds would be realized if out-patient services were available on an insured basis to a greater number of people. Perhaps the need of hospital beds and the construction of hospital facilities could be minimized if a closer study were made of the provision of diagnostic services for ambulatory patients. We do not intend to place so much stress on financial gain that the principles and philosophy of our hospital system would change. Yet, with the vast sums of public money being expended on hospital insurance, the matter of finance is, of course, an important consideration.—*G. McC.*

Go now—fret later

TOO OFTEN during the past few years we have heard busy hospital administrators say: "No I'm not taking a vacation now. I'll try to take a few days later when the pressure is off". We sometimes wonder what toll they pay and what long-range effect it has on their hospitals. For the pressures of the job build up and can have a serious effect on health.

What is the chief characteristic of the executive's position? Its tyrannical demands on time and its continuous mental and physical pressure. And the executive can never escape. Weighty decisions expose him to frequent emotional strains. Advisory and administrative duties build up tension. The man who knows this but does nothing more about it than gnaw his nails can become a major problem in his institution—a grade A candidate for executive neurosis—not to mention coronary thrombosis.

Every executive has a great many things to think about. His alert mind ponders ten matters while the dullard concentrates on one. A man like this must have a special quality to help him keep his equanimity in a world full of stress. When the weary executive has to lead his hospital or department under unusual strain this quality is put to the test. What he needs is the inner calm that follows the frank facing of difficulty, fear and disappointment. The man who works too hard too long loses this. The best balanced people are not obsessively devoted to their jobs. They follow a natural rhythm in work and rest—one answer, at least, to the stress of living.

Each of us has only one body with one set of organs to last him for life. This body, if it is to keep functioning without unnecessary wear and breakdown, must be treated with simple mechanical understanding. It is not a feeble, perishable weakling. It can be pushed far, very far, and find resources to recover. But why place strain upon it needlessly? We know we cannot avoid strain all the time. But if we permit it to continue without taking rational steps to relieve it we may suffer uncalled for damage. The fit man can depend upon his body and his mind. They will remain fresh through crowded days of work, through patience-trying conferences and through critical periods. This fitness can only be maintained by balanced periods of work and rest. A worn out administrator is not a good administrator. So we urge you to be fair to your hospital and to yourself. Take your vacation, and take it on schedule.—*L.L.W.*

Signs speak for you

WHEN I was walking down 49th Street in New York some time ago, I came upon some sidewalk construction. It involved about one hundred feet and meant that pedestrians had to step into the road. The area had been barricaded so that the work on the sidewalk could proceed easily, but prominently placed were several signs which read: "Sorry for the inconvenience—but dig we must for growing New York". The message was signed by the commissioner of public works. The signs put those who had to step into the street in a much better frame of mind than do several signs one sees displayed around our Canadian cities. Many of these have very curt instructions; some of them, in my opinion anyway, are rude.

The little word "please" is not a hard word to spell; it is not a hard word to say. Yet it is very surprising how seldom some people use it. There was a time not too long ago when the words "ladies and gentlemen" meant something. They belonged to an age of gracious living when one showed courtesy toward others. Calling someone a gentleman today is saying almost that he is soft and not in keeping with the times. This is a sad commentary on our present day living.

A sign which one frequently sees is "Keep off the grass". Undoubtedly, the hope of the sign's owner is that people will obey the order. However, human nature being what it is, I doubt if this sign is as effective as "Please keep off the grass". If a sign like this is too big or too costly, one which just says "Please" will serve the purpose.

The way civic officials conduct their business with the public is just as important as the way individuals deal with each other. Every right thinking citizen in Canada realizes that the country is going through a period of rapid expansion. We cannot have a host of construction projects without some inconvenience. This, I am sure, most of us expect and are willing to put up with. Is there any reason why the signs surrounding these projects cannot be courteously worded?

This plea has implications for hospitals too. There are many signs of various types in and around all hospitals. If you wish to build good public relations you must see that these signs are worded accurately and are courteous. I can remember well two signs on a post which stood in front of a hospital. They were placed one above the other, proclaiming: "Admissions. One Way Traffic Only." Have you looked at *your* signs lately?—*W.D.P.*

the patient's point of view

The Questioning Mind

Philip Rickard,
D.P.A. (Lond.), F.C.C.S., F.H.A.,
Regina, Sask.

IT is surprising how little has been written in hospital journals from the patient's point of view, or, to use an American phrase, on patient-centred studies.

We are all fond of using expressions such as "the patient must come first", or "the patient is the most important person in the hospital", but how much meaning really lies behind such expressions? There is validity in the expression "the patient is the most important person in the hospital"—if only for the obvious reason that if there were no sick persons there would be no need for hospitals, trustees, administrators, or, of course, hospital associations.

It is the intent of this paper to encourage the examination and questioning of situations and routines which, no doubt, have existed in your hospital for as long as you can remember.

A patient first becomes involved when his doctor tells him that he has to go to hospital for treatment. This is a great shock to him and his family, and it is lessened only by the extent to which his doctor explains his illness, the probable length of stay, and the course of treatment. When he is notified of a vacancy, all manner of questions arise in his mind. The thoughtful hospital will have answered most of these by sending the patient a brochure outlining what he should bring with him, and indicating the policy of the hospital on such things as clothes, valuables and visiting hours.

Going to hospital for the first time evokes all the same wretched feelings which one gets on first attending a new school. These feelings will be dispersed or increased by the type of reception the patient is given. Worries will tend to disappear if he is welcomed by a friendly person who acts as if she were expecting him. On the other hand, resentment will immediately be created if he is placed in a cold-looking waiting-room and forgotten for some time. The smaller hospitals perhaps cannot have a receptionist for this purpose alone, but this important rôle can still be the responsibility of one person who is on duty at that time. The question that needs to be asked is "What is done at your hospital to ensure that the person in charge of this service fully appreciates her responsibility?" Think about emergency or very sick admissions. Is there not more interest at some hospitals in getting admission papers completed than in initiating treatment?

In our pattern of society, every effort is made to see that as a child grows up he is given more responsibility and the transition takes place until he can stand alone, support himself and make his own decisions. This has been the experience of each patient and so it continues until he is admitted to hospital. Once in hospital the position is reversed and the patient has no more responsibility than a small child. Even his clothes, the last tangible evidence of his former way of life, are taken from him. He has lost control over events and his life is now in the hands of strangers. He is expected to adjust immediately to being a patient and to accept all things that occur without questioning. Though the language he hears spoken around him is English, much of it he cannot understand, for it is full of technical jargon. He hears of blood specimens, G.I. series, E.K.G.'s and many other terms which are used casually but which may leave him and his relatives worried and frightened. A well-written explicit description of the usual procedures which a patient might encounter would surely go a long way in helping to dispel anxiety.

Confusion of language leads us on to confusion of faces. There was a time when a patient saw just a day nurse and night nurse. With a 40-hour, 5-day week in many hospitals, the position has changed. The patient sees different people every shift—not only nurses but aides and technicians. Days off for staff bring new personnel in touch with the patient, who must surely wonder who's who. Surely a name and rank badge would help the patient to identify the staff he meets and put an end to his wondering if the person in the white coat is a doctor or a painter.

There are occasions when a patient has to be taken to some other part of the hospital, such as the x-ray department. Then it cannot be beyond the scope of the administrator's skill to see that a more personalized service is given. Why should the patient have to wait for an unnecessary length of time in a set of new surroundings until the staff is ready? Tension builds up within the waiting patient, especially if the procedure to be carried out has not been explained. After the examination is over it is not unknown for the patient to be left around again because the department thinks it is the ward's responsibility to transfer him, and the ward thinks it the department's.

On the wards the patients are being wakened. Only in the last ten years has anybody questioned the practice of wakening, washing and testing temperatures of the patients at 5:00 a.m. After this flurry of activity they might wait till 7:30 or 8:00 o'clock for breakfast. Now, I believe you can sleep a little later. You, I trust, are quite sure you are aware of the time patients are wakened at your hospital, but before you decide that your routine is perfect, just consider what time you would like to be wakened if you were not feeling too bright.

Food

Then we come to meals and meal times. Many years ago (but not in Canada) I used to hear it said, especially by nurses in training, that hospital food was the worst in the world. That was at the time when there was an alternative menu for staff, though not in the way that you would probably imagine. There was one menu for the staff who were classified as officers and another for the rest. What is the position today? Food,

The author is executive director of the Saskatchewan Hospital Association. He gave this paper at a provincial institute sponsored by the S.H.A. in April 1959.

and the manner in which it is served, as you know, plays an important part in achieving the patient's recovery, yet I have heard it said that because they are unable to keep within the inadequate and antiquated allowance of 75 cents per patient meal day some hospitals are having to cut the quality of food served.

Many of the larger hospitals are able to offer the patient a certain amount of choice in the meals and this is a very good thing. Obviously, the foods a patient likes are those he is used to and we must not overlook the fact that the tastes of different ethnic groups vary considerably. The racial and religious background of the patients admitted to your hospital should be considered when menus are prepared. Some 200 years ago Lord Chancellor Thomas Erskine wrote:

"The French have taste in all they do,
Which we are quite without,
For nature, which to them gave goût,
To us gave only gout."

From the patient's viewpoint and from the public relations aspect, one item that needs more thought than any other is coffee. This, as you know, can vary from a sweet smelling delectable liquid to a muddy fluid which would appear to have been dredged up from the South Saskatchewan River. It should be no more assumed that all North Americans have a divine gift of brewing coffee than it can be believed that all the English can make perfect tea.

Just as there has been some improvement in the wakening hour, so in many instances have meal hours been adjusted to more reasonable times. There are, however, still far too many hospitals that have a mid-day meal around 11:00 to 11:30, and the evening meal at 4:30 to 5:00 p.m., with breakfast appearing between 7:30 and 8:00 next morning. That means the patient goes some fifteen hours on perhaps just a glass of milk. It is certainly not what he has been used to and is obviously arranged because it suits the staffing pattern.

Another rigidly established routine is the giving of medications. Have you ever thought why it should be necessery for a nurse to go around handing out vitamin pills and headache tablets when nurses are supposed to be in short supply? The present system, in addition to being time-consuming, does not even work too well. Routine times are fixed for giving out medications despite the fact that they are not altogether suitable for such a rigid procedure. Medicine ordered three times daily may be intended once every eight hours, but the routine of giving drugs at, say, 10:00 a.m., 2:00 p.m. and 6:00 p.m., results in the therapeutic effect being concentrated over a much shorter period. Again, if a doctor makes a round at 11 o'clock and orders a one-a-day drug, the routine may call for it being given at 10:00 a.m. So the patient may have to wait 23 hours before being given the first dose. Why should not most medications, with the exception of hypodermics, narcotics and sedatives, be given to the patient to administer himself. After all, the patient is usually anxious to get well and he takes these things when he is in his own home. It would give him some responsibility and it is more likely to ensure that he receives the medication at the times prescribed than under the present routine.

Noise

From food let us turn our thoughts to noise. Noise always ranks high on a list of patients' complaints. Much of it can be overcome and remedied, provided we take the trouble to conduct a survey to determine the causes. There is not a great deal of noise in a hospital, but because of the structure and the materials used, there is a considerable amount of echo multiplication, or reverberation. There is insufficient absorption of sound, and hard smooth surfaces like terrazzo, concrete, plaster and glass bounce sound waves backwards and forwards until they die away. The hospital corridor is often an echo-chamber magnifying and multiplying sound. There are two basic cures. The first is to pin-point the cause of the noise and try to remove it, and the second is to assume that there is bound to be some noise and to arrange to have it absorbed. Most hospitals are now fitted in part, at least, with acoustic materials which range from small perforated tiles to large acoustical panels and heavy duty assembled units. These are highly efficient at soaking up noise and can reduce the noise level by as much as 60 per cent.

What then are some of the causes of noise? Some of the most irritating and most difficult to remedy are noises made by patients themselves, such as snoring and coughing. The harsh clanging of garbage containers seems to be a universal problem which perhaps could be overcome by the use of rubber lids. Incidentally, the judicious use of rubber helps to reduce noise. It should certainly be on the shoes of all the staff. Squeaky wheels on trolleys and carts can easily be taken care of if someone is watching for them. The pitch of the telephone bell on the ward can be muffled to a less piercing tone, and the maintenance man should be able to reduce the noise caused by the hammering in steam pipes and the hiss of steam from the sterilizers.

To my mind, the most unnecessary noise comes from radio and television sets. The radio problem can be met by pillowphones, but television is more difficult. It would seem only fair that patients, other than those in private wards, should not have television in the ward unless every other patient in that ward is agreeable. If one balances the disturbance to a sick patient against the limited enjoyment received from the inane programs televised there would appear every justification for a rule restricting the use of television sets to single private rooms and day rooms, and even then the sound should be carefully controlled. One cannot help noticing that the over-bed table has now been converted into a rather expensive television stand.

If you doubt the importance of colour use, read what Florence Nightingale wrote about 100 years ago: "I am inclined to think that the majority of cheerful cases is to be found among those patients who are not confined to one room, whatever they are suffering and that the majority of depressed cases will be seen among those subjected to a long monotony of objects about them. The nervous frame really suffers as much from this as the digestive organs from long monotony of diet.

"The effect on sickness of beautiful objects, a variety of objects and especially of brilliancy of colour is hardly at all appreciated. Such cravings are usually called the 'fancies' of patients, but their 'fancies' are the most valuable indication of what is necessary for their recovery! People say the effect is only on the mind. It is no such thing, it is on the body, too. Little as we know about the way in which we are affected by

(concluded on page 92)

Quantity and Quality

Irial Gogan, M.D., B.Ch., B.A.O.
Calgary, Alta.

MOST advances in medicine and in sociology have followed the lead of voluntary organizations, with governments assuming the responsibility for programs which were, in most cases, initiated by small groups of citizens, acting in advance of their time. Hospital insurance is no exception. The trend at present of government's increased acceptance of responsibility for financing hospital insurance has resulted largely from the over-all popularity of Blue Cross programs. The increasing costs of hospitalization, plus the demand for coverage of the entire population, have given governments a strong political impetus to enter this delicate field.

Inevitably, the entry of governments has resulted in their assumption of total or near total financial control. This follows the principle that the use of public monies involves an equal or greater degree of public or governmental control. There are many arguments to justify the entry of government into the field, particularly because government has for some time accepted the responsibility for indigent and other sociologically problematic elements of the population.

However, there are certain dangers implicit in the assumption of government responsibility for this type of management. There is the very considerable danger of replacing quality of hospital care by quantity. This danger is implicit in the principles of government financial control combined with public demand—as a direct result of eased accessibility to previously expensive amenities. The main difficulty facing governments is the one of maintaining the interest of local management in functioning economically, while restrictive forms of financial control are imposed.

Therefore the fundamental problem facing government is the provision of what is in their opinion a sufficient amount of money in order to satisfy what may be an unpredictable volume of demand for service. Sandwiched between the supply (of funds) and the demand (by the public) are the hospitals which have established and functioning methods of organization and management which may not appeal to the statistically-minded bureaucrat, ignorant of the complexities, as being the most efficient.

Methods of governmental financial control

A number of methods are open to government in order to control over-all costs of hospitalization. The most essential control from a government point of view is on the number of beds set up. Most studies have indicated that where a bed is provided there is a reasonable chance that it will be filled. The actual filling of the bed may not always be governed by the necessity for acute hospital care. Where there is bed shortage, there is probably a natural screening process which involves the performance of a relatively high volume of surgery in relation to total beds, and the treatment of more acutely ill medical cases; a process more evident here than in areas with adequate or superfluous beds.

Where there is this bed shortage one expects to find a decreased number of "casual admissions", and an emphasis on gravely ill patients, which leads inevitably to higher operating costs. It is also rather unfortunate that, although most hospital authorities voice the principle of planned hospital construction, involving not only acute hospitals but chronic and nursing home care as well, over-all planning has occurred only rarely. The pressure for general hospital care has led to the intensive development of acute hospitals and to the neglect of the provision of chronic, convalescent and rehabilitation facilities. Therefore the control on the number of hospital beds does not represent a sufficiently complete method of financial control. In areas of bed shortage there will be higher operating costs per bed than in those where an adequate number of beds exists, although total expenditures will be lower in the bed shortage area, especially if capital costs are included.

The various provincial governments participating in the federal-provincial arrangement have all introduced different hospital plans. That this is so is not surprising, considering the complexity of hospital insurance. The approach used in Saskatchewan, and modified in Ontario, of an approved budget appears to be the nearest to the ideal. However, in Saskatchewan budgetary approval is very frequently six to seven months after the commencement of the year for which the budget is operative. Lately, in that province, an attempt has been made to have tentative budgets submitted, examined and approved, before the fiscal year, with the proviso that modification is possible during the course of the budgetary year. This is a considerable advance. The province of British Columbia has adopted the principle of following one year behind the cost of hospitalization. This has resulted in many of the British Columbia hospitals' having ever recurring deficits with no possibility of ever catching up. The present Alberta approach is extremely experimental in many ways, and involves the payment of "standby costs" up to certain ceiling levels. A deterrent charge represents a service component.

Most of the hospital plans share in common the attempt to control their provinces's hospitals' operation by some statistical method. Statistics are useful as guides provided that individual variations in reporting and individual variations in operational method are recognized. There is an unfortunate trend in some quarters to ignore the fact that each hospital is different and, in fact, functions as an individual. For example, the unenlightened statistical approach may show that one hospital has a very much higher cost of housekeeping than another. The statistics will *not* show that this hospital is of ancient construction and requires an out-of-the-ordinary amount of housekeeping to maintain average standards. Across the

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Dr. Gogan is medical director of the Holy Cross Hospital in Calgary, Alta. He was formerly director of Hospital Administration and Standards with the Province of Saskatchewan.

OSHAWA GENERAL HOSPITAL

W. A. Holland
Oshawa, Ont.

THE Oshawa General Hospital was opened on the day Florence Nightingale was buried — August 13, 1910. At first it was a 16-bed unit, but additional buildings were added from time to time, including reasonable service departments, until 1942 when the Sykes Memorial Wing was opened. At that time the hospital was well separated into departments, with adequate services.

In 1950 a survey was made by Dr. Harvey Agnew and his associates, and he reported that there was no further room available for beds or for expansion of services and that any addition to bed capacity called for modern and enlarged service areas. So the firm of Govan, Ferguson, Lindsay, Kaminker, Langley and Keenleyside from Toronto was selected as the architects for the new building program the following year. The building committee realized that progress would not be rapid as the re-arrangement of departments and general renovation had to be carried on while the hospital continued to operate at full capacity.

The general contract was awarded to Bathe and McLellan Limited of Oshawa, and construction started in August, 1954. The electrical contract was sublet to Hill-Cornish Electric Company Limited and the plumbing and heating contract was sublet to Harold R. Stark Plumbing, Heating and Engineering Limited, both Oshawa firms. In an impressive ceremony the new wing was officially opened on Wednesday, May 22, 1957 by Leslie Frost, premier of Ontario.

The author is superintendent of the Oshawa General Hospital, Oshawa, Ont.

Oshawa General's new wing and front entrance

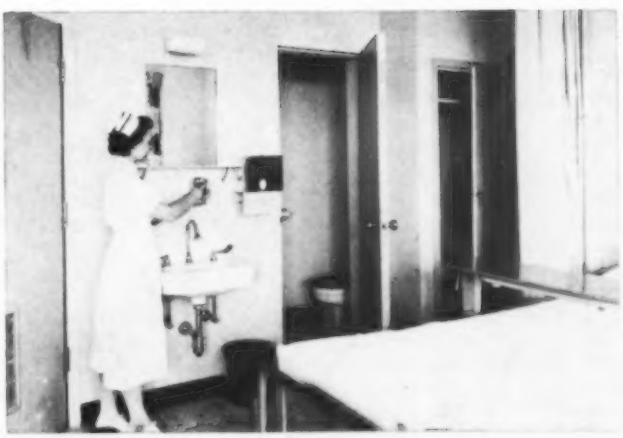
a modern double corridor wing expands facilities

Emergency admitting right at street level.

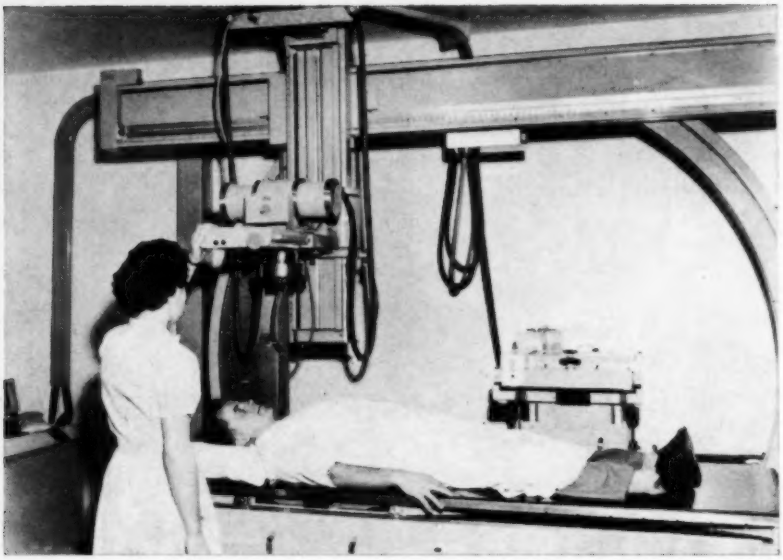
In the main lobby a receptionist waits to answer any question.

Architects:

Govan
Ferguson
Lindsay
Kaminker
Langley
Keenleyside
Toronto, Ontario



A modern patient's room, complete with all facilities.



One of the new x-ray units in use. An entirely new x-ray department was provided in the new wing.

Through the Corridors

The six-storey building is in a double corridor plan, fire proof, with terrazzo floors throughout. Walls are hollow tile, faced with red brick and insulated with two-inch cork and with a modest amount of cut stone. The windows are screened and are of the hinged type to allow cleaning from the inside as well as increased ventilation.

A penthouse on the roof contains the elevator machinery, the circulating fans, the telephone exchange and the controls for the pneumatic tube system.

New Entrance

A new entrance was provided in the new wing—it opens into a public waiting room, well lighted and ventilated. On one side is the gift shop operated by the women's auxiliary. Here also there is access to the telephone operators. The receptionist, ready to answer all inquiries, has her desk in this area too. Two high speed elevators face the waiting room, ready to transport staff and visitors to the upper floors.

On the main, or north, side of the double corridor, conveniently located on each floor, is a drinking fountain, plus a pay telephone and wash rooms. To the west of the waiting room the accounts receivable department and the credit manager are placed between the ambulance entrance and the admitting and chest x-ray areas. The emergency operating room, utility room and a four-bed recovery room are grouped with a nurses' station, waiting room and a bay for stretchers and wheel chairs. Next is a room equipped for cystoscopic work and on the corner is a fracture room.

The rest of the main floor is occupied by the x-ray department and has the usual waiting room, viewing room, directors' and secretarial offices. It has completely new equipment so that excellent plates and treatment can be provided. One room is reserved for electrocardiograph work, and a cloak room for doctors is adjacent to the parking area.

The basement contains a morgue, an autopsy room, locker rooms for the staff and a mechanical room for the water connections, circulating pumps, et cetera. An explosion-proof room is provided for the anaesthetic gas storage.

Medical

The second floor is a 44-bed medical patient floor which includes four four-bed wards, two isolation rooms that can be expanded to four rooms. These are equipped with sterilizers, utility rooms, et cetera. The remainder are two-bed rooms. The patients' rooms are around the outside walls and the services are in the centre, opening on each corridor. A waiting room is opposite the elevators. A bath tub is at each end of the corridor. A linen supply room, designed for truck use, has a day's supply of linen on hand. Soiled and clean utility rooms are provided. Piped oxygen is supplied to each bed.

The nurses' station has a doctors' write-up desk, a medicine room, ample space for desk work and a nurses' washroom. An examining room is provided for the doctors' use. The telephones are dial for both internal and external use. A subdued call system is operated throughout the hospital by the switchboard operators. Messages and small parcels are relayed between departments through the automatic pneumatic tube system and a dumb waiter provides transportation from the central supply to the nursing units. The location in the centre of the department and the use of the nurse-patient intercom saves many steps and lets the nurse conserve her efforts for more important tasks. When the patients are admitted, an addressograph plate is cut with the patient's name and other pertinent information, saving endless rewriting of name, address, et cetera, and resulting in greater accuracy and forms which are much easier to read.

The patients' needs have been well taken care of. Each bed can be adjusted electrically. Each patient has draw curtains for complete privacy. Each room has circulating air, nurses' night lights, provision for a telephone, radio and television electrical outlet, is well lighted and is curtained. Each room has a two-piece

wash room. And each room has lockers for the patient, dresser space, easy chair, visitors' chairs, and bedside tables.

This medical floor is joined to the other buildings at the level where the other medical patients and the children's areas are located.

Surgical

This is a 46-bed ward (third floor) for surgical patients and is on the same level as the floor housing surgical patients in the older buildings. The lay-out and the furnishings are duplicates of those on the second floor with the exception of the isolation section in the medical ward.

Maternity

The fourth floor is the maternity floor, containing one four-bed room, nine two-bed rooms, one premature nursery and four normal nurseries which each hold 12 bassinets of an approved type. A suspect nursery containing five cubicles is also provided. A great deal of thought and consideration was given to this area in order to provide the doctors and nurses with the best equipment and conditions for their work with our new citizens. Only one bath tub is provided on this floor. The central service area with nurses' stations is the same as on the two lower floors. This area connects on the same level with the older buildings and patients' rooms where the maternity department patients are located. A new milk formula room with bottle washer, sterilizer, mixer and refrigerator has also been provided.

In the delivery area, there are 12 labour beds, usually in double rooms. Three air conditioned delivery rooms, utility rooms, work rooms, a preparation room for two patients, with wash room, are to be found here too. Doctors' rest room, locker rooms for doctors and nurses and washrooms are also provided. This area was formerly the surgical operating area.

Operating Suites

The entire fifth floor is used as the surgical operating unit. There are six operating rooms, three scrub areas, and there is a high speed instrument sterilizer in each sub-sterilizer room. Each scrub area serves two operating rooms. The recovery room has seven beds, utility room and office. The department also has an instrument room, two utility rooms, anaesthetic storage room, doctors' locker room, nurses' locker room and a nurses' station.

The floors are conductive terrazzo and there are safety switches, walls tiled to six feet, piped oxygen and air conditioning to control temperature and humidity in each.

Laboratories

The department of laboratories has a director's office, a secretary's office and laboratories for pathology, chemistry, bacteriology, blood bank, haematology and histology. Storage rooms are provided and a special room for cleaning up, washing and sterilizing of glassware is included too. Practically all of the equipment has been newly purchased.

A doctors' library and a lounge has also been provided on this floor.

One corner of the new, well planned pharmacy.

A lab technician uses one of the new microscopes, in her new and spacious quarters.

The pharmacy, consisting of two rooms—one for storage—is in the charge of a registered pharmacist.

The central supply covers a large area of the top floor; it is well lighted and ventilated and commands a picturesque view over Oshawa. It has a clean up area, assembly area, sterilizing area, and sterile storage. The sterilizers have automatic controls. There is also a surgical glove area and a storage room. The pneumatic tube system and dumb waiter serve all departments on this floor.

Steam Heat

A large new building houses two 165 h.p. steam boilers, oil fired. The Bunker C crude oil is stored in two 10,000 gallon tanks, steam heated. The original boiler house has been reconstructed to include a large incinerator and water softeners. Adjoining buildings have been remodelled to provide an engineer's office and work shops for the maintenance staff. A new stack, 125 ft. high, replaces a smaller one that has been removed.

Alert at the station.

The emergency operating room is near the admitting entrance. Piped oxygen is provided and floors are conductive terrazzo.

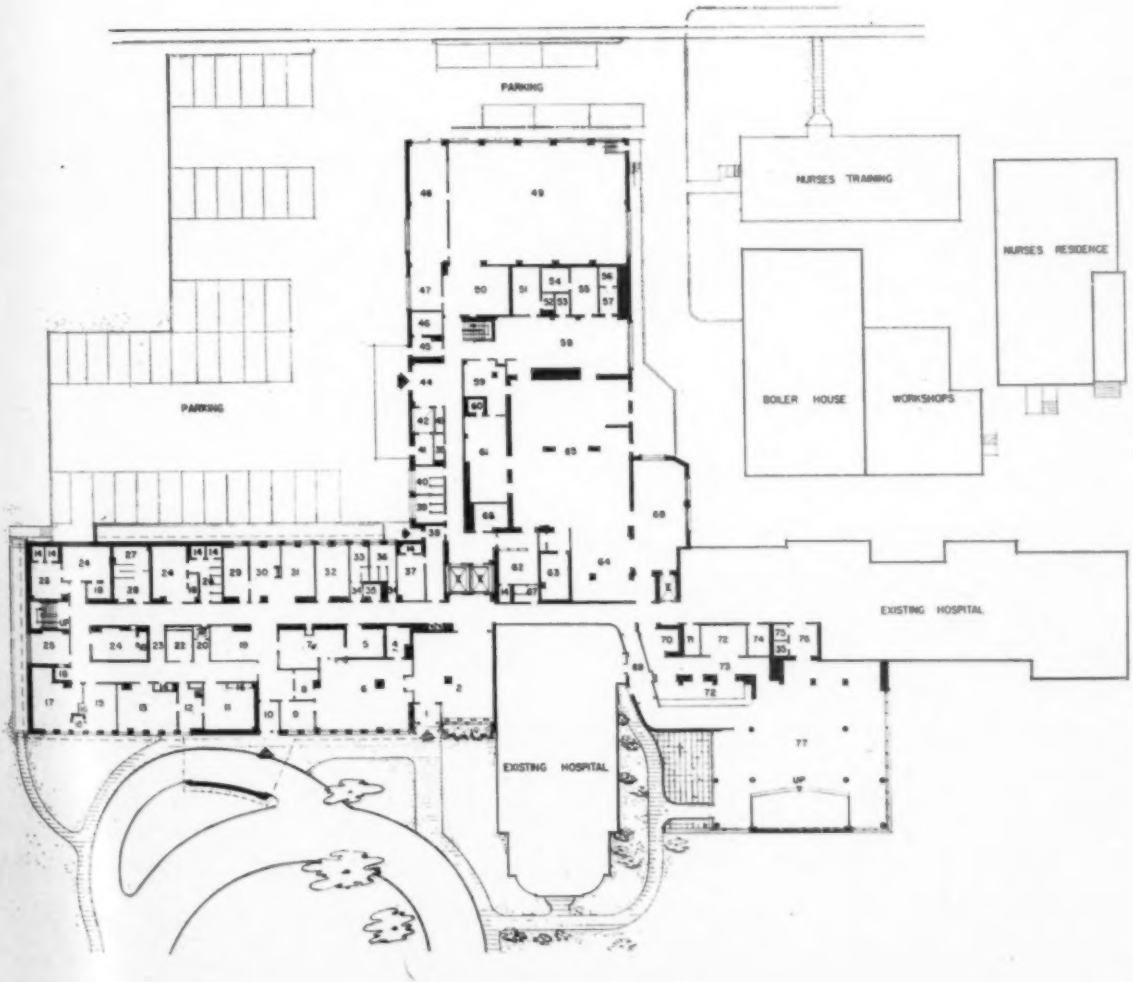
Ancillary Services

A considerable extension was built around the central section to allow for the enlargement of two very important departments—the kitchen and the laundry. The main equipment in the laundry is one six-roll, 120 inch ironer with automatic folder, two automatic unloading washers, two manual washers, one 54-inch and one 30-inch extractor, one 54-inch and one 30-inch drying tumbler. Three press units, each containing three presses, a soiled linen area and a

One corner of one of five new nurseries. Note individual stainless steel bassinets.

Key—Main Floor

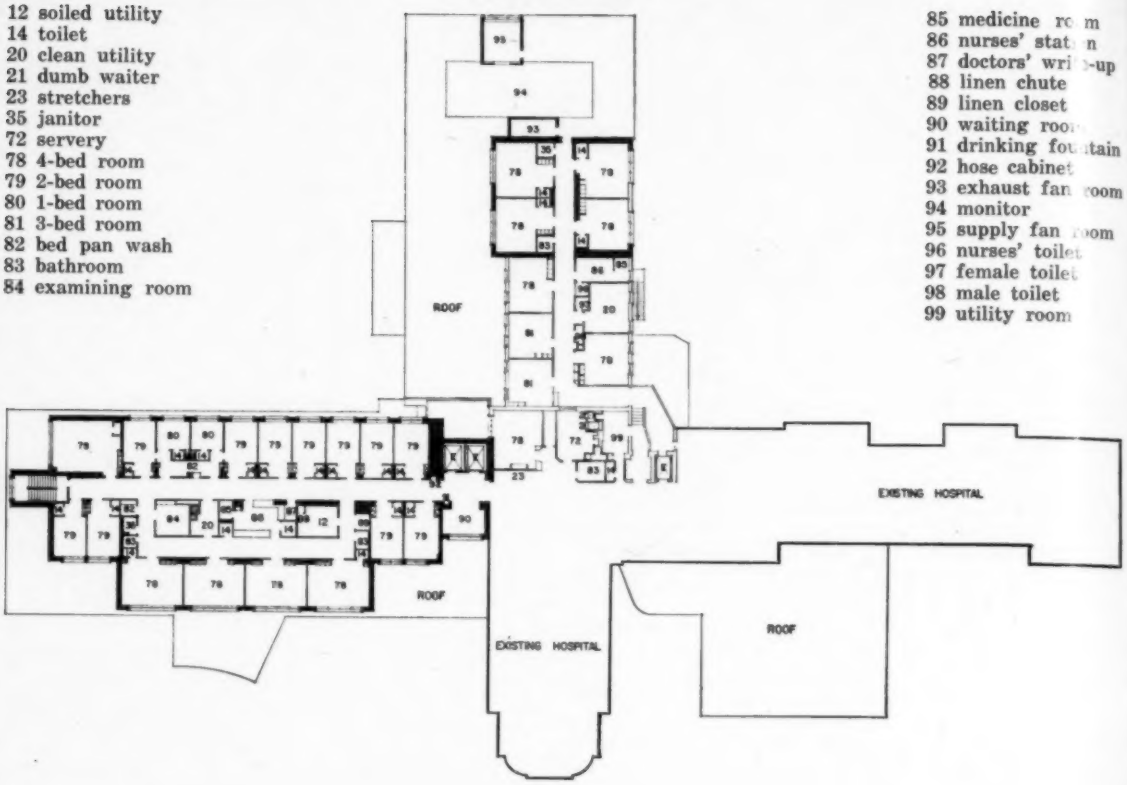
1 vestibule (main entrance)
2 lobby — public waiting
3 telephone
4 vault
5 admitting x-ray
6 general office
7 admitting office
8 cashier
9 credit manager
10 emergency entrance
11 emergency operating
12 soiled utility
13 recovery room
14 toilet
15 cystoscopic room
16 cabinet
17 fracture room
18 control
19 admitting — waiting
20 clean utility
21 dumb waiter
22 treatment
23 stretchers
24 x-ray room
25 therapy room
26 dressing room
27 dark room
28 viewing room
29 director
30 secretary
31 x-ray waiting
32 electrocardiograph
33 male public washroom
34 ante room
35 janitor
36 female public washroom
37 doctors' coat room
38 doctors' entrance
39 female washroom
40 male washroom
41 morgue exit hall
42 freight elevator
43 parcel chute
44 receiving entrance
45 can wash
46 garbage refrigerator
47 sewing area
48 clean linen room
49 laundry
50 soiled linen area
51 meat refrigerator
52 fish refrigerator
53 potato refrigerator
54 deep freeze
55 vegetable refrigerator
56 butter and cheese refrigerator
57 milk refrigerator
58 food preparation area
59 day stores
60 bake refrigerator
61 bake shop
62 assistant dietitian's office
63 holding refrigerator
64 cart area
65 main kitchen
66 head dietitian
67 female staff toilet
68 dish washing
69 vestibule
70 alcove
71 storage room
72 servery
73 servery passage
74 ventilation supply unit
75 storage
76 lobby
77 dining room



Typical Patient Floor

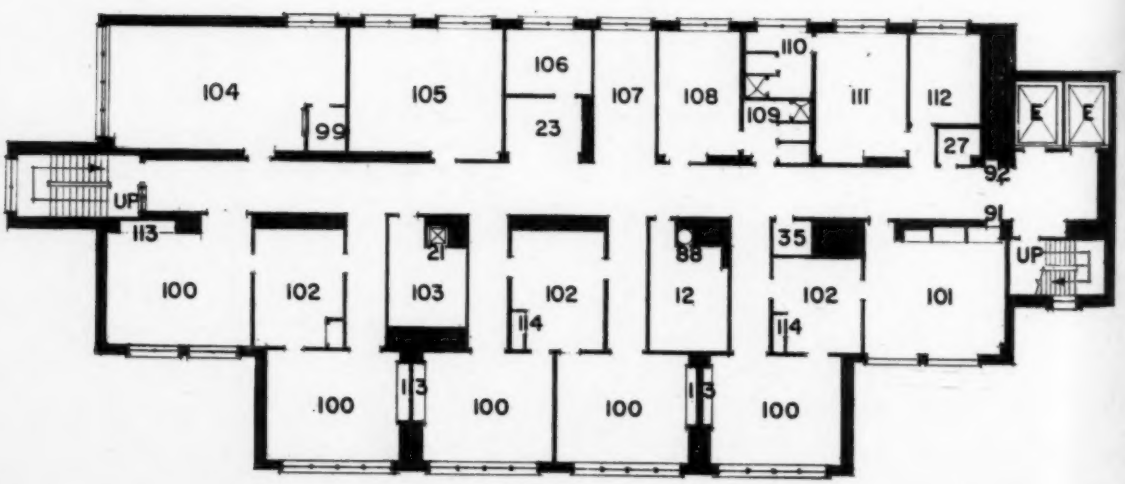
12 soiled utility
14 toilet
20 clean utility
21 dumb waiter
23 stretchers
35 janitor
72 servery
78 4-bed room
79 2-bed room
80 1-bed room
81 3-bed room
82 bed pan wash
83 bathroom
84 examining room

85 medicine room
86 nurses' station
87 doctors' write-up
88 linen chute
89 linen closet
90 waiting room
91 drinking fountain
92 hose cabinet
93 exhaust fan room
94 monitor
95 supply fan room
96 nurses' toilet
97 female toilet
98 male toilet
99 utility room



Surgery

12 soiled utility
23 stretchers
27 dark room
91 drinking fountain
92 hose cabinet
99 utility room
100 operating room
101 orthopaedic operating room
102 sub-sterile and scrub up
103 sterile storage
104 recovery room
105 nurses' work room
106 anaesthesia storage
107 records
108 nurses' locker room
109 nurses' washroom
110 doctors' washroom
111 doctors' locker room
112 storage
113 suture cabinet
114 solution cabinet



combined linen storage and sewing room are provided too.

Food Service

Now, for the kitchen. The northern portion is the preparation area—flanked by walk-in refrigerators to hold meats, fish, dairy products, vegetables and deep freeze units. An open space contains the potato peeler, the butchering section and the salad and vegetable preparation area. The garbage is kept in cans in a refrigerated room near the parking lot.

A store room is conveniently located right at hand in the kitchen area for opened cases of canned and bottled foods — replaced daily from general stores in the basement. A modern bakery provides all the baked goods of the hospital except bread. It has a holding refrigerator. A pot and pan wash area is in use. The cooking area has two banks of electric ovens, electric and gas stoves, deep fryer, grill, pressure steam cookers, and stock pots, automatically controlled. The special diet section is in a separate area, close to the serving section.

Food is placed on trays on a conveyor belt server—hot food on one side and cold on the other. Electrically heated lowerators for china are in use as well as the dry heat method which keeps food warm when it is placed in a stainless steel container. Toast is made as needed by automatic toasters moved to the conveyor line. Ice cream is in a cabinet on the conveyor unit and cold desserts are kept in a conveniently located walk-in, holding refrigerator. The food is delivered speedily by enclosed tray trucks in reserved elevators and served to the patients by the nurses and floor staff.

Light and airy, the new cafeteria allots special tables for smokers.

The kitchen was greatly enlarged and renovated. Here we see the stainless steel tilting kettles and pressure cookers. In the background are ovens, electric and gas stoves and broilers.

The food for the cafeteria is prepared and cooked in the main kitchen and conveyed across the corridor to the cafeteria. The dishwashing section is on the side of the main kitchen and is a centralized unit. A peg type of conveyor machine is used.

The equipment in these areas is of stainless steel. The floors are terrazzo and the ceilings have acoustic tile. The walls are covered to ceiling height with glazed tile. The area is well lighted and well ventilated by forced air circulation.

The dietitian has an office and there is a second office for the dietary staff.

Well-planned, well-cooked meals are served in the attractive modern cafeteria which has been added to the south side adjacent to the kitchens. This is a one-storey, brick building, glassed on three sides; it has a raised platform for large general meetings. The ceiling is dome-typed with direct and indirect lighting. One hundred and seventy people can enjoy the hospital's fine food here, and there is a lounge area of ample size. To help create the necessary relaxed atmosphere, music is piped in during the meal hours. Visitors, too, can use the cafeteria. Special tables are set aside for the smokers and the room has air circulation.

The serving area has warm food storage and refrigeration with two-way entrances; additional refrigerators and counters are used for salad preparations. A cashier stands at the end of the serving counter. Student nurses, however, use a meal ticket.

Other Renovations

The main floor of the Sykes Memorial Wing is now the administration area. It contains the office of the director of nursing

(concluded on page 90)

MORBIDITY STUDIES

Under B.C.H.I.S.

L. F. Detwiller,
M.A., M.H.A., M.R.S.H.,
Victoria, B.C.

TO DATE, the Hospital Insurance Service in British Columbia has limited its efforts in the collection, analysis, and publication of morbidity data mainly to quantitative studies which have related the volume of specific illnesses to demographic, geographic and hospital characteristics. Extensive studies in the field of qualitative analysis as opposed to quantitative have not yet been carried out. Nevertheless, the quantitative data have evoked an interested response from public health administration authorities, medical economists, and voluntary prepayment agencies elsewhere. However, as opposed to this interest in quantitative studies, there has been a noticeable lack of interest in the qualitative field, especially from professional groups.

No doubt this situation in Canada and the United States has stemmed, in part, from the concern of professional groups over the necessity of considering a third party — the prepayment body, be it voluntary or compulsory—in the planning of their affairs.

On the other hand, our system of collecting morbidity data still lacks some of the control measures necessary to produce material of sufficient detail to meet the needs of the clinicians. For example, many hospitals do not have technically trained staff in their record rooms in order to ensure that the basic data on the return form are properly coded and submitted to the Service. Further, the returns may not be submitted in a manner which will allow a proper analysis of the data when they are received in the central agency. There is no doubt that the records maintained by general hospitals in British Columbia could, with some programming, produce qualitative studies in which the treatments and the casual relationships between complicating or attendant diagnoses could be revealed in relation to the diagnoses which are considered the underlying or determining causes of hospitalization.

However, one of the major problems yet to be solved is that of determining the manner in which these data are to be used, so that they will achieve the basic objectives of the morbidity and research programs. In other words, if qualitative studies are to be carried out, do we have the administrative organization necessary to ensure that the studies themselves will ultimately be put to a useful purpose?

Use of Data

The Hospital Insurance Service has turned out compilations of data, cross-indexing the stated primary diagnosis with other patient characteristics such as age, sex, marital status, location of residence, and the hospital in which treatment took place. Such studies have been of unquestionable value in various phases of the direct administration of the Service, particularly in the assessment of the need for construction of additional hospital accommodation. From the information gathered from the more than a quarter of a million admission-discharge records received by the Service each year, it has been possible to pinpoint those areas which record more hospitalization than is average throughout the province. In many instances, it has been possible to determine that this additional hospitalization is the result of more frequent admissions for specific diagnoses and/or longer periods of treatment for certain illnesses. For example, these statistics were recently responsible for the saving of an additional floor in two hospitals. Had the Service not been able to present the hospital boards concerned with statistical evidence showing that their plans were somewhat expansive, then the hospitals would likely have been overbuilt with additional expense being incurred for both capital and operating costs. Today, both the medical staffs and boards of trustees of these institutions are well satisfied with their buildings and publicly acknowledge the guidance received from the Hospital Insurance Service. This advice consisted mainly of being able to determine an estimate of potential patient demand by three statistical breakdowns of their load. The first run dealt with patients from the area then treated in the hospital, the second with patients from the area who were treated elsewhere, and the third with patients from outside the area who were treated in the hospital.

In addition to this type of tabulation, patient data have been examined and empirically correlated within given areas to the age, sex, and occupations of the area's population, the availability of medical personnel, the accessibility and occupancy of hospital accommodation and finally transportation. Such correlations have made it apparent that the degree of use is not dependent on illness prevalence alone, but is influenced by many other factors, among which the varying public demand for hospital care and the local habits of practising physicians are particularly noticeable. Such factors as these, combined with the unique geographic features of British Columbia, have tended to preclude, for the present, the establishment of any fixed formulae on which bed needs can be routinely assessed. If and when the province adopts uniform administrative areas on which population and other relevant statistical data may be routinely released, and when the provincial growth has ceased to have violent effects on the population characteristics of certain areas of the province, it may then be possible to devise norms on which the routine assessment and construction of beds can be par-

Mr. Detwiller is assistant deputy minister of hospital insurance, Victoria, B.C.

tially allowed. Even then, the human element will remain.

It has become obvious through our studies that generally where beds or physicians are in good supply, the incidence of hospitalization increases. Therefore, to build to the evidence is not always realistic. If it is known through our morbidity data that people are resting longer in bed or are asking for beds in degrees which deviate significantly from the average for the type and activity of the population, then construction may be forestalled or recommended by the Service to a degree not necessarily related directly to the demand of the given area but rather to an average for areas believed to have similar population and economic characteristics.

In the 1959-60 fiscal year, the expenditure of the Hospital Insurance Service has been set at $49½ million, including some $7 million for hospital construction. It is, therefore, to our interest to maintain a close appraisal of the volume and type of hospitalization, not only as it relates to the operational costs of the Service but also as it affects the demand for further accommodation. Here, morbidity studies have been of great use in outlining the bed distribution by type of service. Such studies have revealed, in some instances, that apparent total bed shortages were, in actual fact, the result of misallocation of existing beds and that reallocation of, for example, maternity space with women's surgical facilities or paediatric accommodation could realign unit occupancy rates so that the need for construction was overcome.

Thus, much of the work which has been undertaken in the last few years with morbidity statistics has been designed to answer or, at least, throw light on some of the problems encountered in the administration of a government prepayment hospital scheme. This has been of special interest to individuals interested in the development of government schemes, for in British Columbia we have, in the ten-year period in which we have been in operation, changed from the type of hospital program to be found in the south, that of a partial voluntary prepayment plan, to a province-wide premium payment scheme. We now operate a hospital scheme financed on the general revenues of the province and the federal government. In British Columbia, hospitalization is no longer the responsibility of the individual. Today, it is a person's right, provided he is a resident of the province. It has been placed alongside law enforcement, education and other services which are provided through government sponsored channels.

Comparison Value

Although some of our findings have been useful to other administrative groups, the quantitative morbidity picture which has resulted from the studies referred to above may be quite different from that which could emerge from similar work in other provinces. Therefore, comparisons of morbidity experience must be tempered by a knowledge of the circumstances under which the data are collected. Cognizance must be taken of the demographic, ethnic, and cultural backgrounds of the populations being studied, and of prime importance is the availability of accommodation and medical personnel.

As hospital prepayment programs develop, there will, no doubt, be comparisons of one area to another, particularly with reference to hospital utilization rates. Such comparisons should have as their ultimate objective the economic improvement of facilities for the patient, and should be used with care not only as reasons for deterring government expenditures for hospitalization but also as instruments showing where better care is needed.

Finally, while the various organizations operating insurance plans across Canada can spend a great deal of time and money in gathering and analyzing morbidity data, the data will be of little value without the full co-operation and support of the medical profession in their application. Co-ordinating and advisory medical committees to provide hospital plans with the necessary professional evaluation of medical problems are desirable for the ultimate success of any province-wide hospitalization program.

The author

Tools for Evaluation

Some ninety-six years ago, Sir John Simon, then medical officer to the Privy Council in England, deplored what he termed the "grievous imperfectness of hospital statistics", which was such that "we cannot by such statistics accurately compare even in part (much less in entirety) the success of one hospital with the success of other hospitals."*

Hospitals are repositories of much information which, if processed and collated on a comparable basis, could produce extensive commentaries on varying clinical and administrative procedures, and hence on the standards of patient care being produced. The routine collection of information from a large group of hospitals could provide a basis for evolving standards of measurement which can reflect advances in technical procedure. This means the production of norms periodically, and gives rise to such operations as the professional activity study. In this rapidly moving age, when medical discoveries are being almost daily accepted into routine practice, the need for flexible norms with which to measure results is of initial importance. Comparisons of procedure, if based on out-of-date yardsticks, are, in themselves, useless as measurements of standards of care, and could be very misleading if they do not take into account the newer advances in medicine. Medicine is a rapidly changing science. We must make certain that the "tools of evaluation" keep pace with it and are viewed in the proper perspective by qualified authorities. It would seem advisable at this point to expand somewhat on the term "tools of evaluation".

**McKay, Donald and Charles, Sir J., Hospital Morbidity Statistics, General Register Office, H. M. Stationery Office, London, 1951, p. 9.*

Quantitative studies involve numerical calculations or manipulations of data under such headings as: patient days, length of stay, incidence of illness, number of cases of a specialized diagnosis, and so on. There is no attempt made to determine whether or not the number of patient days is excessive, the length of stay too long or too short, the results only being final arithmetic determinations in themselves.

Qualitative analysis, however, involves something much more than arithmetic since it requires an interpretation of the arithmetic results as applied to particular fields which, in this case, are those of medical and hospital care. On the one hand, this may only involve the carrying out of studies which arrange and compare the experience of various hospitals in certain fields or their experience in the treatment of certain disease. For example, a study of 100 hospitals might show that their average length of stay was 9.5 days with extremes ranging from 6.8 days to 12.4 days. By studying a compilation of the group, it may be determined where a hospital is situated in relation to the others. This position could cause satisfaction or concern, depending on the position in the study, the type of hospital, and the individual receiving the report. Usually, organizations carrying out this type of study do not attempt to pass judgment on any hospital. Instead, they send the results of the analysis back to the member hospitals for their information; any further evaluation and resulting action are the responsibility and decision of the hospital and its medical staff.

On the other hand, there are some organizations such as the accreditation commissions and companies carrying out professional medical audits who are prepared to evaluate professionally the results of the tabulations and make recommendations on the care being provided. Such an evaluation program is an extension of the medical audit of a hospital so that the basis for comparison is much broader than is possible in a single institution. However, care must be taken that such an evaluation program is carried out only by people competent to express medical opinion; namely, the medical profession. However, a great deal can be done to prepare data in a form that will permit easier handling by the evaluation group and at the same time provide a body of data that will permit individual hospitals to determine what their experience is in these fields by comparison to the care which is being provided elsewhere. By combining this latter program with a professional review of the statistical data, both quantitative and qualitative results may be obtained.

Complete Records Necessary

The completing of an accurate medical record presents formidable problems in many hospitals. In British Columbia, about 50 per cent of our active treatment beds are located in some 90 per cent of our public general hospitals. Among this 90 per cent of the hospitals, the average capacity is 48 beds, while the range is from nine to 150 beds. Add to this fact the thought that the medical staff in some of the smaller institutions is often limited to one or two doctors, and the problem of producing complete medical records begins to emerge. Data cannot be tabulated and processed unless records are completed in some detail by the doctors in these institutions. Every attempt is being made by our inspection teams to emphasize the necessity for complete medical records, but the time problem of the doctor who serves single-handed a population of as many as 3,000 people, scattered over miles of lonely, rugged country, is not an easy one to solve. His daily schedule of surgery, office, home, and hospital visits would defeat the average person's physical capabilities, and such a man frankly states that he does not find time to write up more than the minimum of information about the diagnosis and treatment of his patient. The unfortunate results emanating from the haphazard maintenance of records in smaller hospitals has already been demonstrated in our attempts to collate patient data. Further complications have been encountered in those hospitals which have no personnel specifically allocated to the maintenance of medical records. At first glance, this may not seem to be a problem of any magnitude, but there is some concern when we realize that only 43 per cent of our public general hospitals have any trained staff to complete medical records. In many of the smaller institutions, the admitting clerk enters the diagnoses required by our present regulations, and these diagnoses are obtained in a verbal exchange with the attending physician. This is a realistic point of view. The results of such exchanges can be highly unsatisfactory, but the small hospital does not have much choice in the selection of personnel, and the variety of duties allocated to the administrative personnel often precludes the completion of records with comprehension and accuracy.

From a cost point of view, it does not seem possible that trained personnel could be employed in each institution, and yet from the very limited morbidity studies which we have undertaken, it is apparent that it is these same small hospitals which are most urgently in need of some method of comparing standards of service and care. The larger hospitals, with active medical staffs and alert medical records departments, do ensure that the patient's record will be accurate. Consideration could, of course, be given to the idea of limitation or suspension of payment of per diem rates to those hospitals which fail to organize their records. However, such a restriction would be a penalty on the patients and the institution and immediately such a stand were taken other factors and issues would become involved. It is therefore impracticable. This is a problem which is present in hospitals of comparable size in other provinces.

On the other hand, if cost were no object in the setting up of professional activity studies on a province-wide basis, the problem of employing adequately trained staff would be greatly reduced. However, the fact that additional trained personnel might have to be budgeted for within many of our hospitals in order to implement the collection of useful data, immediately creates financial difficulties in budgets that are already having problems in keeping up with the addition of new services and the extension of the old. Perhaps the development of professional bodies similar to the Commission on Professional and Hospital Activities would do much to overcome some of these problems of record keeping and lack of trained personnel.

Granted these difficulties do

(concluded on page 84)

The Nature of Administration

Sister Y. Aubert,
Lewiston, Maine

Let us remind ourselves now that all types of administration—hospital or business—will be effective and durable only if directed toward the achievement of a predetermined goal, a lofty ideal, which is socially desirable and attainable. Administration can never be an end in itself as some seem to believe it to be. It is but a means employed to lead, in the ways of science and wisdom, all those who have chosen to help bring about the accomplishment of the hospital's purpose—good patient care. It has been said that no man with limited objectives will ever attain his goal.

Many things have happened to hospitals within the past 25 years. They have grown in size, their functions and organization have become more and more complex and the problems which come with growing pains have increased the need for better administration. Since administration and communication are phases of the same process, there arises a need for better communication in order to coordinate the work of many people and many services toward the goal of giving good medical and nursing care to patients. The patient has been, is still, and will always be the *raison d'être* of hospitals all over the world, a fact which the administrator must never lose sight of.

Now — to consider how the administrator can, through effective communications, keep a hospital functioning in the most satisfactory manner possible. His chief concern is the patients' welfare. The patient, then, becomes the guiding star in the unremitting task of administration. This sick person who is suddenly torn away from all that is familiar to him—home environment, family and friends—and is thrown into a place filled with strange people, strange sights, strange sounds and strange machines, is exposed to this at a time when he is least capable of defending himself and when he is really filled with fear and anxiety. It is little wonder that we see men known in the community as burly, good-natured chaps turn out to be whining, finicky children during their hospital stay. The administrator personifies strength and the patient weakness. Yet when they are drawn together because of the obligations of one and the needs of the other, how can they meet on common ground? It is my belief that they can meet through continued and effective communication. What are some of the means by which the administrator can establish good communication with the patient, his relatives and friends?

The administrator as the preserver and restorer of health

Gilbert Highet, educator and critic, has said that "in health or sickness, the administrator is an educator", and certainly this is true. Although he may never teach a formal course or conduct a class, he will communicate at all times to his associates and co-workers his philosophy and knowledge in order to develop the means to provide the type of care the patient expects when he enters a hospital.

Each day will not be peaceful for the hospital administrator. But in spite of the headaches, he will have moments of deep satisfaction, a reward for his efforts toward creating an atmosphere in which the art of healing will develop and mature. In such an atmosphere, the doctors, the nurses and all other personnel will work together in perfect harmony to ensure security and comfort to all those seeking renewed vigour and health. The patient will find many new friends whose sole interest will be to help him recover his previous state of health. And living in this atmosphere will be a blessing for hospital personnel, as well as for those who are patrons of the institution.

Here is a thought which may be a determining factor in effective communications. "The hospital has something to offer which nobody wants." We know this to be so. Therefore, the administrator has

LET us pause and take a good look at the word "administrator" to determine just what it stands for. Could we not say that the administrator is a leader, a mobilizer, a director, a co-ordinator of both human and material elements for the achievement of a major aim or purpose? And how better can the administrator attain this purpose and fulfill his obligations than through effective communications? It would seem that the very nature of administration is in itself a complement, an application of the communicative process. For it is the medium through which the administrator transmits his ideas, his ambitions and his wishes to his associates and co-workers. Writing, speaking, listening and acting all belong to the *armamentarium* of good administration. And need we be reminded that to be effective, words and actions must be chosen carefully so that the ideas they arouse in the receiver are close enough to the sender's ideas to result in understanding?

If one wished to elaborate on the administrator's communications, one would have an endless, although gratifying, task; for communication is to the hospital administrator what the scalpel is to the surgeon—a tool which he must use with the greatest care and dexterity or be ready to pay a high price for its misuse. It is not always "what" but "how" the administrator communicates which will either alleviate or aggravate any situation. This is very true when one considers the implementation of hospital policies. It is said somewhere that good hospital policy cuts and polishes the facets of effective communication. A good administrator would not forget this statement when interpreting to employees, and through them to patients, formulated hospital policies. He must be very careful to see that both the subtle as well as the literal implications of the policy be transmitted, for in this way only will he be able to impress upon the patient and his family the fact that the policy functions for their ultimate benefit. Thus interpreted, hospital policies make the reputation of the hospital, generate good will and reflect credit on both the hospital and its chief executive.

Sr. Aubert is director of nursing service at St. Mary's General Hospital, Lewiston, Maine. From a paper presented at the H.O.M. summer session, 1958.

the responsibility of building an atmosphere which will satisfy the most demanding patient. He must strive to keep this atmosphere alive by (a) developing and maintaining good public relations; (b) educating the patients and the community in the value of hospital-community relationships; and (c) developing new techniques and methods which will facilitate and maintain high standards of administration and favour the progress of medical science. This is of major importance and requires from the administrator judicious, expert and tactful performance which he will achieve through effective use of communicative skills. Within this atmosphere the administrator must also develop an attitude conducive to growth and development, an attitude which will automatically flow from his own convictions and his personality. These are some of the tools that will help the administrator convey his ideas in the hope that they will blossom forth into the activity he is trying to initiate.

When hospital people evaluate a hospital they do so in terms of number of beds, percentage of occupancy, variety of services, quantity and type of specialized equipment, number of professional and non-professional workers, et cetera. A patient's criteria are altogether different. As the administrator's guest, he will want to find out if the group of professional and non-professional workers is sympathetic, understanding, anxious to see him through his ordeal with the least possible discomfort. He will want to know if the medical and the nursing care is adequate, if the hospital policies have been formulated for his benefit and that of his relatives and friends, if the employees are conscious of his needs and are anxious to meet these at all times, if he is considered a welcome and honoured guest and not just another case number. What kind of personality would you want your hospital to have? The kind that reflects kindness, understanding and hospitality? Since this personality must be a direct reflection of the chief executive's, we would like to prescribe for the administrator a magic formula which is bound to produce the ideal type of executive.

1. We would like this hospital leader to have genuine humility.

2. We would like him to have the authority necessary to fulfill his obligations effectively.

3. We would like to see him enveloped with the type of modesty which will lead him to seek advice from the wise.

4. We would like to see the administrator govern wisely. Who needs to be wiser than he who helps bring health and life to the sick?

5. We would also like the administrator to have an uncomplaining and unpretentious fortitude which will help him establish rules and policies and enable him to smooth out the problems that hinder the service to the sick.

6. Lastly, we would like to see the administrator equipped with courage enabling him to carry out his decisions in the face of much contradiction and meet the challenge of his office.

The physician as the keeper of health

The restoration and preservation of the health of patients is one of the administrator's many responsibilities. He disseminates the information which he holds for the welfare of the sick. To do so, the administrator will have to gather about him competent and skilled associates—doctors. No one would deny that the physician is as essential to the hospital as the hospital is to the physician. Anything that disturbs this relationship is bound to make the patient suffer. And it is the public that will be the final judge of our actions. The administrator, therefore, must set up good lines of communication to establish and maintain close relationships among the hospital, the medical staff, the community and the patient. This is by no means an easy task, but it is the administrator's share of the care given to patients.

How will the administrator strengthen staff-administration relationships, an essential ingredient of medical care? He must develop and promote direct lines of communication that are kept open at all times and used frequently. In this way and in this way only will the administrator get to know the members of his medical staff as individuals, with individual characteristics. He must maintain hospital-staff friendship. Some means of fostering this would be: giving recognition to the physician as a man of judgment and quality, able to seek the cause of illness and to apply his knowledge of healing processes; accepting the nature of the physician as it is without trying to change it in any way since we must make the best of what each one has to offer; learning to work with all types of people—numerous contacts help broaden one's views; developing faith and confidence in the physician's ability and skills, for the patient quickly senses the hospital personnel's lack of confidence in a member of the medical staff; assisting in the organization of the medical staff by promoting self-government; developing an organized knowledge of medical matters in order to deal intelligently and wisely with medical staff problems; providing man power, materials and equipment in sufficient quality and quantity to enable the physician to do his work well; and educating the medical staff in the progress made in human relations, executive management and in communications.

The human and public relations in the hospital lean heavily on the ability of the administrator to communicate with his associates as well as with all the personnel hired to care for the sick. But these also depend on the frequent meetings the administrator has with the patients and their friends. A visit to the hospital wards for a friendly chat with the patients—to inquire about the care they are receiving, to investigate their grievances or to gather a frank statement of how the services could be improved—will go a long way to establish the kind of relationships every hospital administrator would like to see in his hospital.

The administrator as the co-ordinator and educator

We have considered the administrator as a preserver and restorer of health, as the person who gives the incentive, the impulse toward the goal, as the leader who guides his associates in their search for better ways of treating the patient. Let us now follow him as he operates and co-ordinates the intricate machinery of administration, and look into the methods he uses to educate those who are pledged to the service of the sick. The administrator is the mobilizer, the animator of all the activities within the hospital, but he must remember that he is a human being with limitations, and consequently he must rely on others to supplement his efforts. To these co-workers, the hospital administrator must delegate responsibilities with commensurate authority to accomplish their duties. His ability to train

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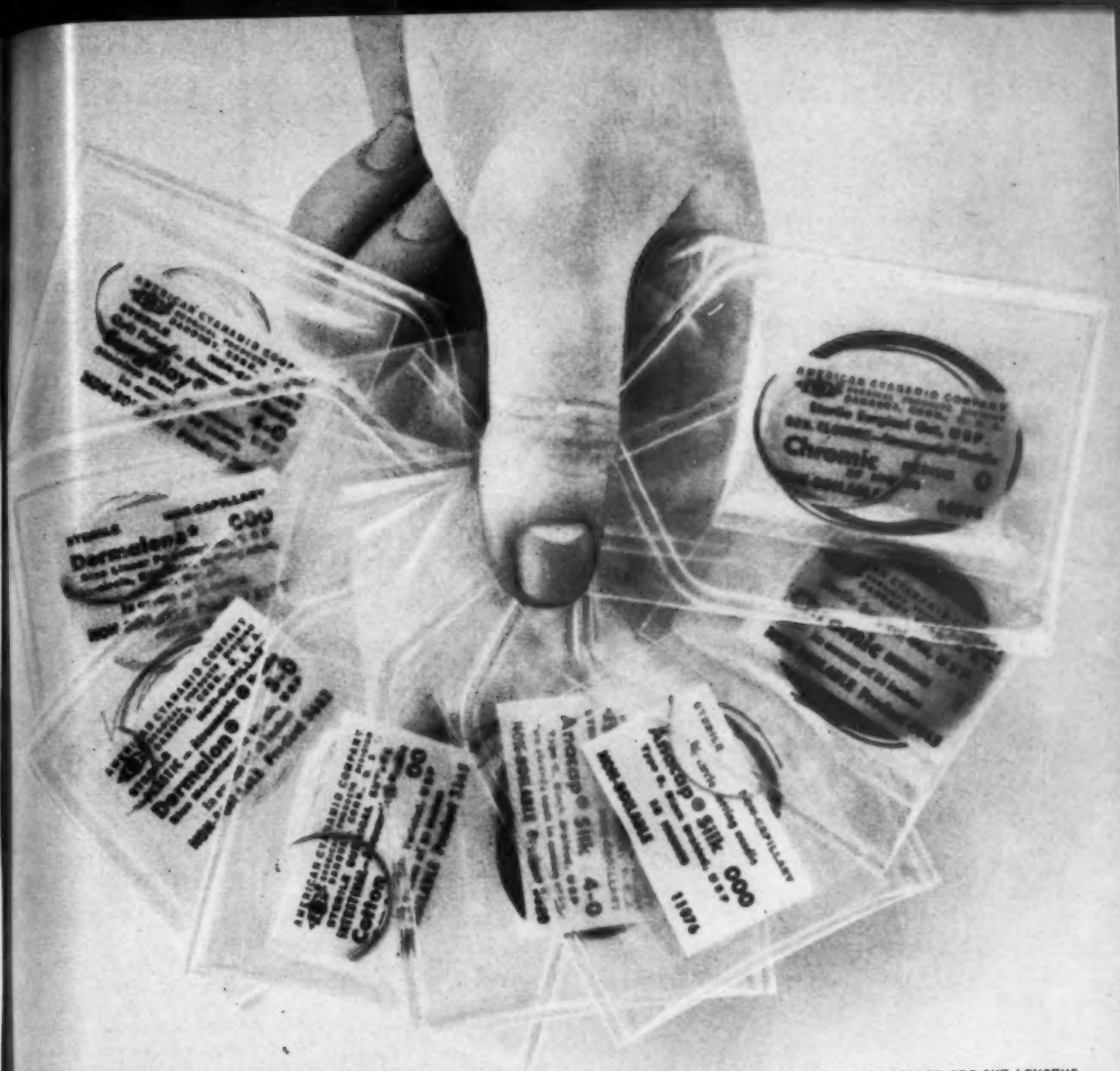

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The Trend is Upwards

use of hospital services is analyzed and studied

D. W. Ogilvie,
Toronto, Ont.

WITH nine of Canada's ten provinces now committed to the provision of hospital insurance systems, it can be said that the hospitals' age-old problem of financing their day-to-day operations is practically eliminated. However, the financing of the hospitals' operating costs is but one facet of any over-all consideration of the hospitals' function, services, and the use of these services.

Because payment for operating costs is now assured through the spreading of these costs over the whole community, our responsibilities today lie in seeing that the available services are used to the fullest and best advantage. Our problem now is partly stated in one of the provisions of Ontario's Hospital Services Commission Act, which reads: "the development of a balanced and integrated system of hospitals and related health facilities". To guide us along the road to this objective, help is at hand through close study of the prevailing trends in community attitudes toward hospital care, and trends in the actual utilization of hospital services.

By tracing the evolution of hospitals, we find that they have come through various stages—from being despised as filthy hovels to the position where today they merit, and enjoy, public confidence. In fact, so much do hospitals now enjoy public confidence that one of our major concerns is to develop ways and means of keeping hospitals from being used unnecessarily.

In the past few decades the transition in the use of hospital services has been affected by three main forces: (a) the changing pattern of patient care; (b) the introduction of prepayment systems; and (c) sociological changes within the community. These forces have not only been parallel to each other but, it is strongly suspected, in some ways they have been entwined. By this I mean that the changing pattern of patient care which created new demands upon our hospitals, also helped to raise the financial problems which resulted in the development of prepayment systems. Prepayment increased as a factor, partly at least, because of certain sociological changes, such as the tendency to greater urbanization. As prepayment systems grew and developed, they made hospital services more readily available, and this has made it possible for medical science to advance treatment techniques more rapidly than it might have otherwise. To complete the circle, as medical techniques have advanced, the use of hospital facilities has become more prevalent.

The prepayment systems have been a very important factor in contributing to the increased use of hospital services. I do not believe, however, that prepayment in itself is by any means the only influence. It is but one of the three basic factors in the changes which have taken place. Let us examine the trends in the light of these other factors to see what problems, and perhaps solutions, these trends indicate.

I was very much interested in an article which appeared in the March issue of the *Canadian Journal of Public Health*, by Dr. Lawrence E. Ranta, assistant director of the Vancouver General Hospital, which is entitled "Medical Staff Control of Hospital Stay". Dr. Ranta makes the point that only a few years ago, the chief factor in sending a patient to hospital was the physician's estimate of the clinical needs of his patient compared with the economic resources of his patient. When considering whether or not his patient should go into hospital, the doctor asked himself some questions. For example, was he, the doctor, justified in having the patient pay the additional costs for care in a hospital? Or, was his patient ill enough to really need hospital care and still pay both the doctor's and the hospital's bill? There were, of course, other concerns but a main question was economically centred: Could the patient get adequate value for his dollar in the hospital?

Then among other changes, including those related to the changing practice of medicine, came prepayment. At this point Dr. Ranta goes on to say:

"The doctor had to adjust to a changing situation. Specifically with respect to hospitalization, it was as though all his patients had suddenly inherited a fortune. Each of them had a bank account, a nest egg, that could be used only to buy hospital service. The doctor now found that he had to change the sequence of his questions. Did his patient need the in-patient services of a hospital? And, what did he mean by 'need'? Now, certain of his patients who required hospital care, but who formerly could not afford it, could be added to the group of those who could go to hospital. Moreover, the doctor could assess much more leniently the conditions of the patient's environment which might suggest the need for hospital care. These and other factors have brought about the inevitably greater use of hospital facilities wherever a hospital insurance program has been introduced."

While on the subject of prepayment as a factor for the increased use of hospital services, I would like to refer to a study which was carried out jointly by Michigan Blue Cross and their State Medical Society; 12,000 consecutive clinical records of patients admitted to a group of general hospitals were analyzed by experienced doctors using very conservative criteria to determine need for hos-

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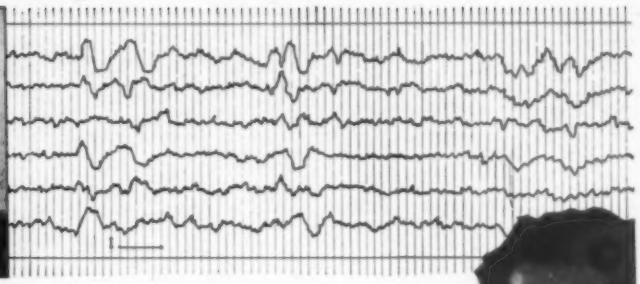
Mr. Ogilvie, director, Hospital Insurance Branch, Ontario Hospital Services Commission, gave this address at the 15th biennial meeting of the Canadian Hospital Association in Montreal, Que., May 1959.



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pitalization. It was found that nearly 15 per cent of hospital days were considered to be unnecessary to either the recovery, or safety of the patient. Insured patients misused their hospital stay nearly twice as often as those who paid their own bills to the hospital. The study indicated that almost one out of every five hospital days used by insured patients was not an essential day. Although it is true that the very reason hospital plans were introduced was to make hospital services financially available to the public, it is obvious that we must be sure this conveyance on the road to speedy recovery has adequate brakes!

For the sake of comparison, and as a basis for further discussion, let us see what has happened in the rates of admission to hospital:

In Canada as a whole, the estimated admission per 1,000 of the population in general and allied special hospitals rose from *115* in 1948 to *145* in 1957.

During the same period each 1,000 of the population showed an increase in days of care from *1,383* in 1948 to *1,681* in 1957.

Despite early ambulation, there has been little change in the average length of stay in public general hospitals. The national average has held at about ten days.

Looking at Ontario's experience, we find that the provincial admission incidence per 1,000 rose from *110* in 1948 to *141* in 1957. However, the admission incidence for Ontario's Blue Cross insured residents rose from *119* in 1948 to *155* in 1957. Incidentally, during this same ten year period, Ontario's hospital costs jumped 265 per cent, while wages and salaries paid to hospital employees increased 400 per cent.

Additional statistics are available which indicate greater use of ancillary services at increasing costs. However, I think it unnecessary to burden you with more figures to indicate that the trend is ever upwards. This is certainly no news. Neither will it be any shock to realize that the upward trend will probably continue for a number of years at least.

Why this constant upward trend? What can we do to keep it to a minimum? How can we cope with the inevitable?

First let us consider why the use of hospital services has shown a steady increase, not only across Canada, but also throughout the United States.

The Population Trend

The percentage of people aged 65 and over is constantly increasing, and a report by the Blue Cross Commission in 1957 indicates that, measured in days of use, the cost of being in hospital in this age group is from three to four times higher than that for those under age 65. The age 55-64 group, which is *constantly* growing because of the increased life span, uses three times as many hospital days as those in the 35-44 age group.

The fact that we are living longer, therefore, has a very definite influence on the use of hospital services. Perhaps it is ironic that one of the major reasons we are living longer is the better medical and hospital care available.

Socio-Medical Influences

Much could be said about the effects of the changing pattern in our mode of living and the changing pattern in medical practice.

Urbanization is, of course, one of the main factors tending to send greater numbers of people to hospital. As increasing numbers have moved into the cities, many one-family homes have become multiple family dwellings and apartment buildings have soared skywards. When sickness comes to these people, the hospital is the logical place for them to go. Surveys show that the urban population uses more hospital days per 1,000 of population than the rural group. There are probably minor exceptions to this. For example, Saskatchewan's experience indicates that greater rurality was found to be one of the important social factors in areas of highest hospital use. The truth probably is that either extreme, that is greater urbanization or very heavy rurality, has the same effect.

Working wives are another cause of greater demands upon the hospital. For, when father or the children become ill, there is no one to take care of them. Many more facets of the social influences could be cited, of course, but I think they can be summed up in the fact that hospitals today have now become an important and accepted part of our way of life. The whole community now has an interest in hospitals because the *healthy* as well as the sick, through our prepayment systems, are involved in paying the cost of hospital care. Having paid for care through taxes or premiums, they feel it their *right* to go to hospital when the need arises.

From the medical standpoint the hospital has assumed greater significance as the place where the doctor can best treat his patient. Advances in medical science permit doctors to offer treatment to patients whose conditions were classified as hopeless and incurable a few years ago. Also there is the great increase in the number of specialists in the medical profession and the specialists are, in general, the large users of hospital facilities.

There are sound reasons why we should all be very much concerned about this tendency to increase use of hospital facilities. One reason is economics—the costs of hospital services have never been higher than they are today. Another concern is that we make efficient use of all available facilities, not only because the capital investment in hospitals is almost astronomical but, just as importantly, because there is a limit to the available supply of trained personnel without whom a hospital would be little more than a hotel.

Much has been said about the use of financial controls in the form of co-insurance or deducted amounts paid by insured patients when in hospital. When the terms of Ontario's insurance program were considered, the pros and cons of co-insurance or deductibles, were debated at length. Our insurance program has been introduced without co-insurance because of our belief that co-insurance is not a proven solution to the problem of abuse, and even if co-insurance functioned as intended, it is undemocratic, striking too heavily on those requiring long-term care. Moreover, it was felt that the imposition of a co-insurance charge would create an inequity since the co-insurance amounts would serve as deterrents only to the poor.

I think it goes without saying that control of the use of hospital services must rest with members of the medical profession. When we ask the medical profession to assume this control, we are asking only that they exercise their professional judgment to determine what is, and what is not, necessary to the treatment of a patient.

We are very pleased in Ontario with the way medical committees are being established in hospitals to support the physicians in their decisions on which hospital services are or are not necessary. The Ontario Medical Association has recommended to hospital staffs the

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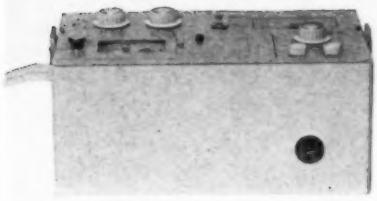

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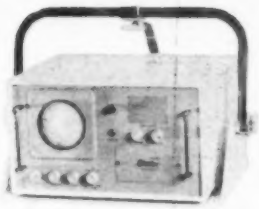

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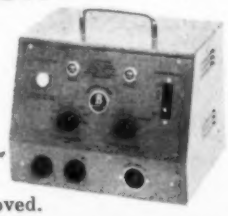

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The case for psychiatry in a general hospital

R. A. J. Krizanc,
Edmonton, Alta.

FOUR hundreds years ago, Sir Thomas More, in his famous *Utopia*, described community hospitals this way: "They are furnished and stored with all things that are convenient for the ease and recovery of the sick; and those that are put in them are looked after with such tender and watchful care and are so constantly attended by their skillful physicians that, as none of them is sent to them against his will, so there is scarce one in a whole town that, if he should fall ill, would not choose rather to go thither than lie sick at home." Thanks to leaders like Florence Nightingale, general hospitals have achieved considerable progress toward such a goal, but mental hospitals appear still to have a long struggle ahead.

At present, 98 per cent of all hospitalized mental patients are cared for in mental hospitals. These institutions are usually located in austere, prison-like surroundings far from major settlements. Their quality of service is handicapped by overcrowding, lack of an adequate number of psychiatrists and other personnel, and the large number of custodial care patients; and the stigma which a large section of society still attaches to mental illness is an added burden. The returning patient, influenced by the attitude of society and the forbidding environment, feels himself to be a pariah and prefers to keep silent about the experiences during his stay; thus depriving the hospital even of the grateful praise of those for whom it cares.

As a solution to the problem of isolation, prejudice and overcrowding, the conviction that psychiatric treatment should be, as far as possible, community-centred is gaining increasing support. The general hospital is a place into which such services can be integrated. It is the hub of community health activities — in it are centred preventive, diagnostic, and active treatment, as well as rehabilitation and education and research programs. With it are associated community leaders actively interested in health problems (*e.g.*, physicians, nurses, board members). It is conveniently located and the surroundings are pleasant.

The patient can seek treatment within the general hospital without feeling he is an outcast, and he usually can avoid the legal entanglements of certification. The family doctor, whom the patient considers a friend and who has probably known the patient for some time, is continuing to care for him as a member of the treatment team (teaching the family, who may have rejected the patient or smothered him with oversolicitude, to accept and understand him and his needs). The family and friends are encouraged to visit him frequently and thus they keep him in close contact with the home and community. Often it is possible to treat the patient in the out-patient department or as a day or night patient. This allows him to continue with his everyday life. When discharged, he is accepted by the community with the same sympathy and consideration offered to other patients returning from hospital.

By treating the patient in the community general hospital, the psychiatric team gains distinct advantages:

(a) In the more relaxed and familiar atmosphere, the patient discards his anti-social attitudes, becomes more self-confident and cooperative. This improves his prognosis greatly and shortens his hospital stay.

(b) By looking at the case in its own setting, the team can appreciate better any faulty relationship that may exist—at home, at work, or in the community. It can forestall new complications and plan more smoothly the patient's rehabilitation.

(c) The team can make use of the full range of diagnostic services and medical records available at the hospital, and it can organize the follow-up through the out-patient department.

(d) The team can enlist the help of the family doctor and consultants on the staff, as well as physiotherapists and occupational therapists. Often, in a medium-sized hospital, the engagement of such personnel is warranted only after a psychiatric department has been organized.

The clinical experience which the family doctor gains as a member of the treatment team gives him new insight into psychiatric problems. Not only does this enable him to give more effective help to the mentally ill, but it also allows him to apply his broadened knowledge to great advantage in the treatment of his physically ill patients. According to some authorities, up to 50 per cent of patients in a general hospital who are treated for physical conditions have mental problems contributing to the cause of their illness. The family doctor will approach their social and emotional problems with greater understanding and, because he can consult the psychiatrist and social worker when necessary, he will be able to prevent the development of more serious difficulties.

The physician does profit greatly by the inclusion of a psychiatric department in the hospital organization. The staff as a whole is influenced too. A new outlook on mental illness develops and the result should be a more positive attitude toward the mentally sick and better patient care in general.

Hospital disaster plans should include provisions for the treatment of psychiatric cases. The staff should be prepared to deal with hysterical and confused patients, particularly during the initial period of severe stress. They should also be ready to look after the rehabilitation of serious psychotraumatic conditions when the first emergency has passed.

In the out-patient department of the general hospital, emphasis can be placed on prevention of mental illness. Here the general practitioner sends his patient for thorough investigation and here people come to seek help even before they realize they may have a psychiatric problem.

To integrate the psychiatric ser-

(concluded on page 115)

The author is with the Hospitals Division, Department of Public Health, Edmonton, Alta.

The Independent Auditor—

his rôle is control

Walter W. B. Dick, C.A.,
Moncton, N.B.

ONE of the reasons advanced for the introduction of government-sponsored hospital insurance is that more will be obtained for less. In other words, each dollar expended for hospital care is expected to yield more units of service. Obviously, this anticipated state of efficiency can only be accomplished by the application of administrative controls of the highest order.

Today, the post audit of financial transactions by an independent professional auditor is widely acknowledged and accepted by both business and government as a prime requisite in attaining and ensuring effective economic control. Thus, the main function of the independent auditor is to produce control information. It is evident, then, that administrative decisions based on anything but factual information would lead to improper and unsatisfactory results. Hence, the rôle of the independent auditor, in examining and expressing an opinion upon financial data, an opinion aimed at ensuring its accuracy as well as freedom from bias, is an important one.

Furthermore, what the auditor contributes here is not only for the planning and reimbursing agency which in this instance is the provincial government but is also for the policy people of each hospital — the members of advisory and trustee boards.

Since control comes about from the application of many management techniques and procedures (of which the audit is but one) these observations on the rôle of the auditor deal also with some of the common services of the professional accountant. Such services are, of course, related to the acquired skills and knowledge of the auditor based on tested education and experience. Undoubtedly, the first step in evaluating the auditor's rôle is to examine the audit function.

The Audit Function

One of the most illuminating descriptive terms applied to this task is the French term *verifacteur*. This word's origin is in the words truth and do. And the audit is concerned with the truth of things done. As a matter of fact, its prime purpose is to express an independent opinion on the reliability of financial transaction representations made by interested parties.

When the trustworthiness of the information in financial statements such as the balance sheet and the operating statement has been established, the auditor expresses his opinion in what is technically known as the "Auditor's Report", and commonly known as the "Auditor's Certificate". This short, narrative report, which is attached to the balance sheet, sums up the scope of the examination and important qualifications, if any, involved in the expression of opinion.

The author

Unfortunately, the brevity of such a report causes certain general misconceptions about the amount of work that goes into the examination. Regardless of the size and extent of what is under review, the auditor must observe professional audit standards. There are, of course, differences in the procedures of verifying financial transactions and presentations. These differences stem from several factors. Some of the most important are: (a) the state of the accounting information under review, including such things as internal control; (b) the known use of the information included in the financial statements being reported upon; and (c) the skill and integrity of the auditor.

Coming out of the past is the idea that the auditor is a policeman whose main interest is to catch bookkeepers taking, without approval, assets (never liabilities) from employers. This is, of course, an historical myth. In a famous legal decision on auditors, their function was aptly described as that attributed to the watchdog and/or bloodhound. Let us hasten to say that this description should in no way detract from the social and humane characteristics of persons in this type of service.

At the same time, the increasing complexity of the financial aspects of organization requires skilled services for the audit function, if objectives are to be attained with efficiency. It is, therefore, in the economic and social interests of all those concerned with the provincial hospital plan — the government agencies, the hospitals and the subscribers—that the independent auditor be employed to express an opinion upon the financial statements of institutions which serve the sick and injured. Here government agencies become trustees of the public resources collected for the purpose of providing hospital care. A necessary requirement is the obligation of the trustee to see that such resources are distributed for the precise purpose for which they were mustered. In employing the independent auditor, the government agency as trustee is using one of the best safeguards available in modern society for carrying out the duties of this office.

There is also the need for devel-

(concluded on page 64)

Mr. Dick is chairman of the Committee on Accounting and Statistics, Canadian Hospital Association. From a paper presented at the Hospital Administration and Budget Institute, sponsored by the Hospitals Services Commission of New Brunswick, in Fredericton, N.B., March 1959.

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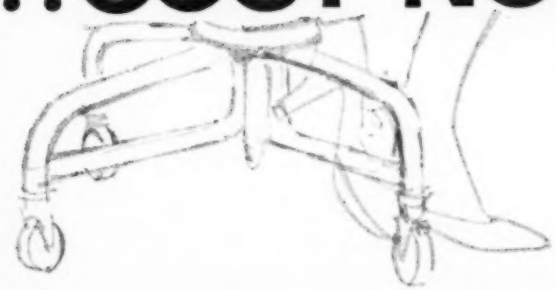

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oped skills. It is true that aptitude is an important ingredient, but formal training and experience are also demanded. For an auditor to reach the place where he can accomplish the tasks outlined here as the audit function, he must have a certain standard of knowledge and judgment about matters of accounting and finance. At the moment at least, it is in these two phases of administrative responsibility that the independent auditor can perform useful service since there is an apparent and acknowledged need for guidance.

Accounting Service

Since the basic training and experience of the independent auditor is in accountancy, it is only natural to look for expert advice here. Fortunately, the independent auditor is usually prepared to give guidance on the most suitable type of accounting system to be adopted, keeping in mind the objectives of the organizational effort. For example—is its prime purpose profit or is it a non-profit service such as the voluntary hospital? Another important characteristic kept in mind when the auditor advises on the accounting system is the organizational arrangement which is determined by administration to be the most effective way of reaching goals. In mind is the departmental or service centre designation of responsibilities found in the hospital. Influences of lesser degree on the design of the accounting system are the personalities directing the affairs of the organization.

The observations offered here on the accounting system imply that not only must the auditor offering advice be familiar with the most effective way of recording financial transactions but he must also have a real understanding of objectives and administrative arrangements.

With such knowledge, experience and understanding, the independent auditor is able to assist in developing not only record forms but also procedures that minimize effort and improve internal check. Anyone working in hospitals today knows the real and urgent need there is for this type of assistance. Internal check—which involves the keeping of records in such a manner that each clerk's work automatically confirms the accuracy of the other—brings to mind the matter of internal control. For various reasons, not the least of which is the administrative arrangement with the attending doctor, there is not too much evidence of internal control of the kind that is reported to exist in profit making ventures. Part of the process of internal control is internal check, already mentioned, and internal audit. Here again, the independent auditor is in a position to give advice and direction in the introduction of this proven tool of management—internal control. Now, an aim of all accounting is to provide information for making business decisions. This information is found in its best form in periodic financial statements—monthly and annual. Experience reveals a hesitancy by administrative personnel to use financial statements.

Unquestionably the small use made of periodic financial statements in the past may be attributed to a lack of understanding of their nature and purpose. The time is now here, since monthly statements are a requirement of the provincial hospital plan, for hospital officials to familiarize themselves with their use. Part of the accepted definition of accounting includes the thought that it embraces the interpretation of financial statements. The independent auditor, familiar with financial statement analysis, is available to help hospital personnel acquaint themselves with the potentialities of a full understanding of financial statement interpretation.

One of the hallmarks of a good accounting system is its picking up quantitative statistical data along with the double entry financial transactions. In addition to an anticipated saving in clerical effort, an improvement in the accuracy of statistics is expected. The latter is in the interest of control. Recording paid hours of work in the payroll is indicative of the thinking in this regard; recording patient days in earning records is another. The imaginative independent auditor can help a great deal in correlating records to dollar data and quantitative statistics.

These observations include only a few of the aspects in accounting where the services of the independent auditor acting as advisor can be useful in hospital administration.

Financial Counsel

Out of the independent auditor's experience in accounting and the audit function comes an understanding of finance. In particular, the auditor develops a high regard for the principles that have evolved in the solutions to the dilemmas faced by the entrepreneur. These problems have occurred in long term financing as represented in bonded indebtedness. Furthermore, it is a certainty that the independent auditor would point out the dangers of a continuous series of operating deficits to the future financial stability of an institution.

Over the years the professional independent public accountant has been recognized for the sound character of his advice on matters of finance. Therefore, when problems of this nature arise in hospital affairs, prudent administration seeks the counsel of those most familiar with the ways to solutions.

Another place where the independent auditor is useful is in representations by the hospital to other parties for recognition of their financial claims. Part of the respect for the auditor's advocacy of presentations is derived from the independence of his position; there is more respect for his ability to demonstrate the facts involved.

Preparing financial budgets is largely a mechanical process. As a matter of fact, they are much easier to develop than the familiar historical statement. Generally speaking the problems associated with budgets have to do with the preliminary planning. At the same time, it is this advance planning that yields the major benefits to administration. For it demands that administration think of its objectives in terms of dollars for operating expenses and income as well as capital needs. What follows is merely recording the results actually achieved and checking them with the estimates. It is clear, then, that the major control feature of the budget is in the planning. The actual results only give evidence of the accuracy of the planning.

Because of his varied experiences, the independent auditor may be a real comfort to the uninitiated and inexperienced in the development of their first budget.

Conclusion

In this world of uncertainties there is one certain thing at least—when and if better economic control is effected, it will be done through an accounting arrangement. Undoubtedly, the independent auditor as an expert accountant will take an important part in any such arrangement. It is apparent that the professional accountant is a good man to know and use because the independent auditor's rôle was certainly created for control. ■

Fuel for the Fire

M. T. F. Carpendale,
M.D., M.R.C.S., L.R.C.P., M.S.,
Edmonton, Alta.

A FEW months ago an 80-year-old man was referred to our rehabilitation ward from a nursing home. Three months before his admission he had suffered a stroke, which had left him with paralysis of his right arm and leg and some difficulty with his speech. Previously he had always enjoyed excellent health, had never been in a hospital, and had never had any serious illness. He had a low blood pressure and no impairment of his senses or mental faculties. A few days before his stroke he had spent the afternoon gardening.

Following his stroke he was admitted to hospital and treated on bed rest for a month. At the end of this time he showed no improvement, and if anything, he was more listless, apathetic, tired more easily, and became easily confused. It was felt that he would be bedridden for the rest of his days and so he was transferred to a nursing home. On admission to the nursing home he was restless, confused and plucking at his bed clothes. The authorities were afraid that he would fall out of bed and so he was put in a strait jacket. He remained in this for two months until he was transferred to Edmonton. On admission, what a pathetic sight he was! A frail old man twitching at the blankets and moving restlessly around the bed. However, from a neurological point of view, there seemed to be no reason why he should not be trained to be capable of completely looking after himself. After he had been on the training program for some time it became clear that although he knew fairly well what to do, he just did not have enough energy to enable him to do it. Reports from the nurses on the ward indicated that he was not eating or drinking well. My impression was that without special attention to his nutrition he would make no progress. We were particularly anxious to improve his protein intake and help rebuild some of his atrophied muscles. We called in the dietary service and they suggested and provided a commercial protein hydrolysate, to be taken like a milk drink at meal time. The patient enjoyed taking this, unlike his attitude toward most of his other food, and within a week he was showing more energy. Since that time he has shown a slow, but steady, improvement; and now, instead of being dependent on other people in all his self care activities, *i.e.*, getting in and out of bed, dressing, washing, feeding himself, et cetera, he is capable of performing most of these tasks himself.

I am sure that the major factor in changing this patient's life from one of total dependence, despondence and depression to a steady climb up the ladder to independence, optimism and sense of dignity, was the change in his nutritional status. This was the fuel to bolster the fire providing the energy for the patient to progress.

You may say that surely this is an uncommon problem. But it is not. In rehabilitative medicine, prolonged bed rest and subsequent malnutrition is one of the most common and most difficult problems.

Each doctor, depending on his interest or speciality, thinks of rehabilitation in a different way. You hear of rehabilitation of the blind, the deaf, the cardiac cripple or the patient with tuberculosis. But, though I think of all these when I think of rehabilitation medicine, I want to stress here one particular group: that which comprises disorders of the locomotor system. By this we mean any disorder which impairs movement at a joint or affects locomotion. Thus, a disease within the joints, such as arthritis, because it restricts range of movement at a joint, is a disorder of the locomotor system. A disease of the muscle, such as muscular dystrophy, weakens and therefore impairs movement, and so belongs to this group. Diseases of nerves, such as polyneuritis or poliomyelitis, and diseases of the spinal cord following injury, *e.g.*, broken necks, or following disease, multiple sclerosis, also cause paralysis and impaired movement. Injuries or diseases affecting the brain, such as cerebrovascular accidents which cause strokes, cerebral palsy, encephalitis, brain injuries, all may cause impaired movement.

All disorders of the locomotor system have two common characteristics. Firstly, they all cause some impairment of movement. This may range from lack of movement in the big toe because of gouty arthritis, to lack of movement in every joint in the body except the toe, as found in severe cases of poliomyelitis.

Most of us who enjoy the freedom of movement that goes with good health, do not easily picture the shackles which bind many patients with disorders of the locomotor system. Have you ever thought for instance how a patient, with rheumatoid arthritis fixing his elbows in extension, manages to dress himself? Have you ever wondered how a patient who has paralysed arms and legs manages to feed himself? Have you ever imagined what it is like to have a stroke and lose the use of your right arm and leg? Can you tie your shoe laces with your left hand? Can you cut your meat with your left hand? Have you ever thought what it would be like to be a cerebral palsy child and to have so much inco-ordination in the arms that when you try to feed yourself the food goes everywhere except in your mouth? Yet these are the problems that daily beset all those patients with disorders of the locomotor system.

The second thing which most

Dr. Carpendale, director of rehabilitation, University Hospital, Edmonton, Alta., gave this address to the Alberta Dietetic Association in the spring of this year.

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of these disorders have in common is that they are usually permanent, frequently progressive, and seldom reversible. In other words, they produce a chronic disability and they account for a large proportion of all chronic illness. The United States Commission on Chronic Illness has shown that three out of four of the daily sick toll are due to chronic illnesses like these.

Strokes account for nearly one per cent of the disabled. In a city like Edmonton one could expect to find between 2,000 and 3,000 patients afflicted with strokes. If you admitted all these patients to hospital there would be no beds for any other patients! These figures give some idea of how common chronic illness is and, especially, disorders of the locomotor system.

Another fact that should be mentioned in connection with chronic disability and illness is that it is much more common in the older age group. In fact, it is because of the increase of our life expectancy that chronic illness has become the problem of our time. Previously many people died before they reached the age when they might develop arthritis or have a stroke. Also, 20 years ago the person who suffered from a stroke frequently died from intercurrent infection. Today, not only will the average child at birth live to an age when he may suffer a chronic disability, but also he will live longer with the disability. When one considers that the population over 65 years of age in the United States increases by more than 1,000 a day—it is a small wonder that chronic disability is so common.

When we speak of nutrition in rehabilitation it is this group of locomotor disorders that we consider. What is rehabilitation and how does nutrition affect it? Rehabilitation is the process whereby a disabled person attains the maximum physical, mental, social, vocational, and economic usefulness of which he is capable. The whole program is valueless without motivation, *i.e.*, the patient must desire to get well. It is also valueless if the patient doesn't have the energy to carry out his training program. All the most skillful rehabilitation therapists and techniques cannot help the patient who has no spark or no energy. These are things you can provide.

To return to our example case. The day before his stroke this bright, energetic old man was cutting the hedge in his garden. Surely by the next day he had not lost all his strength and interest in life—as he had when we saw him three months later! What had produced this change? Surely it was bed rest. Bed rest is our worst enemy in the fight to maintain nutrition and maintain an interest in life.

Do you know that in six weeks of bed rest a *healthy* person experiences: nitrogen loss equal to four pounds of muscle tissue, calcium loss leading to osteoporosis and renal calculi, phosphorus loss, impairment of creatimine metabolism, stiffness and soreness of joints, deterioration of stance reflexes, impairment of circulation, decrease in blood volume, increased generalized weakness, and profound psychological changes? Bed rest is the worst treatment for any chronic disorder of the locomotor system unless it is specifically indicated.

Supposing, however, that bed rest is essential to therapy, then the dietitian becomes one of the most important people in the team because the patient's nutritional status must be maintained at an optimum level. I will not insult you by telling you what you should feed him. The importance of maintaining nitrogen balance, the difficulties of protein absorption in elderly people and the use of androgen to give positive nitrogen balance are all well known to dietitians. However, it is of no value providing the fuel if it does not reach the fire and how often do we see first class food left by an emaciated patient because it is unappetizing?

I have always believed that the science of nutrition is providing the correct fuel for the fire. Sparking the fuel or getting it into the fire is the art of nutrition. There is no need for any conflict between science and art, but how often there is! I once knew an Austrian cook who made the most exquisite puff pastry. A friend of mine spent many months trying to reproduce it. She used the same quantities of the same ingredients, the same utensils and, as far as one could see, the same methods. But the cook produced ethereal light puffs and my friend had only solid, thick clumps to show for her effort. One had the art, the other did not. If a patient had needed "puff" pastry to stimulate his appetite, he would have survived or succumbed depending on who made his pastry.

This may seem far-fetched, but all too often one sees a meal that would be suitable for an active, hungry labouring man left at the bedside of an elderly bedfast patient. Bedfast patients are rarely hungry (their metabolism is too low to produce hunger) but they must take in suitable quantities of essential foodstuff. To get them to do this, we must make them want to eat. One must use every available resource to titillate their taste buds and to stimulate their appetite. Once this is accomplished the maintenance of their nutrition becomes simple.

You know that for a disabled man to get a sense of satisfaction from life he requires a sense of self respect and dignity. To acquire this, he needs to be independent. To be independent, he needs training. To complete training, he must do exercise. To do exercise, he needs energy. To acquire energy, he needs food. To ingest food, he needs a good appetite.

Therefore for a disabled man to get a sense of satisfaction out of life, he needs at the beginning a good appetite and a suitable diet. Dietitians and home economists are the best equipped to give this to the patient, and in this way they are the key personnel in the rehabilitation team. ■

Dietetic Section of O.H.A.

The dietetic section of the Ontario Hospital Association has planned an interesting session during the annual convention. It is to take place on Tuesday, October 27, in the Tudor Room of the Royal York Hotel. For the morning, to begin at 9:45, the following speakers and topics have been scheduled: Diet and Degeneration, by Alick Little, M.D.; The Older Worker, by L. F. Koyl, M.D.; and Diets and Dyspepsia, Facts and Fallacies, by J. R. Bingham, M.D.

Lunch will be followed, at 2.30 p.m., by papers on Human Genetics, to be presented by Norma Ford Walker, Ph.D., Department of Zoology, University of Toronto; and People and Organizations, to be given by J. A. McIntyre, associate director, Department of University Extension, University of Toronto.

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Proctor A. Dick,
Chatham, Ont.

HOSPITALS have evolved from a compassion for mankind by groups of every faith. These people felt that the physical well being of the individual was an important factor to be considered not only as part of their own philosophy of religion, but for the bettering of the community. It therefore follows that the methods of organizing the original hospitals were as varied as the groups themselves. But from them, grew the concept of the public general hospital—a hospital supported by non-denominational groups, or the general public.

Those who have worked in the hospital field realize that the provincial department of health has found it necessary to develop laws under which hospitals can operate. The department has also found that some regulations are necessary to ensure the safety of the patient, and that the conduct of personnel in hospitals—both professional and administrative—should be established. Now, over the years, the trustee has figured very largely as a controlling factor in these plans. For the responsibility for a public general hospital lies squarely on the shoulders of the trustees. Thus any procedure carried out in the hospital which might be considered malpractice, or when any employee of the hospital fails to do those things which are ordinarily expected of him, the trustees are held responsible — according to the standard constitution and by-laws provided by the provincial department of health.

This may appear frightening, and it may be that you will take a closer look at the constitution of your local hospital. Even if a hospital has no written constitution or by-laws these responsibilities should never be ignored.

The trustee is also charged with the responsibility of selecting an administrator and of assisting in every way possible the development of an organization to give service to patients in the best possible way.

Whether your hospital operates under a religious order or under a general hospital charter, the major expense comes from salaries and wages for the necessary personnel. It is logical then that we should take a good look at this cost in order to ensure that, first, the service rendered does not depreciate; and secondly, that the cost for maintaining that service does not increase disproportionately.

Job Analysis Survey

Many organizations have spent much money in developing personnel programs, but I am not sure that all hospitals have concentrated their efforts on this sort of plan. The very nature of the personnel of a hospital more or less indicates the difficult tasks that confront anyone who undertakes to reconcile, on the basis of the work to be done, the peculiar abilities that are required for each of the various jobs. With the co-operation of three hospitals, the directors of the Ontario Hospital Association have authorized a job analysis survey to glean information that will be helpful in establishing schedules of remuneration, work loads, and other factors involved in both dollar cost of maintaining a hospital and the labour content that goes into that cost.

We all know what is going on in the labour field among hospitals of our province. Pressure from all sides is going to be brought to bear on hospital boards so that various types of hospital personnel will gain higher remuneration. Machinery should be made available by which hospital boards can measure their labour costs and can control them. Some sort of assistance should be given in negotiating labour contracts. It may be that collectively hospital boards will have to work with each other, whether they are bargaining on the basis of a public general hospital or of a religious organization, so that uniform practices for wage rates and benefits can be kept in hand.

From my experience, I would suggest that some of the most disturbing factors in labour management problems are those outside of the wage rates. It may be that conditions are such that the employee is not happy and he will remain unhappy regardless of the amount of pay he receives until the irritating situation has been removed.

One of the recognized plans of operation in personnel relationships is that of keeping communications open. Also lines of communication must be established which will help the staff to understand their work problems and to have the knowledge to perform their duties in the most satisfactory manner. Professor Amos E. Neyhart of Pennsylvania State College has done an outstanding job of establishing training courses for supervisors across the North American continent; and it all started from the simple premise that automobile drivers who had accidents did so only because they were untrained or did not know how to avoid accidents. From this Professor Neyhart went on to develop a training program for drivers and for supervisors of drivers which has extended all the way from California to Maine, from James Bay to the Keys of Florida. One of his pet theories is that if the employee has not learned, the teacher has not taught. I firmly believe that this is the only safe assumption that we can make about our training programs in the hospitals.

Of course, as a hospital trustee, you will ask, "How do I figure in this program?" You hire an administrator who should be schooled in all these procedures and techniques of management, and it is his business to interpret and establish personnel policies and to exercise authority in seeing that all these policies will be adhered to. Your hospital may be

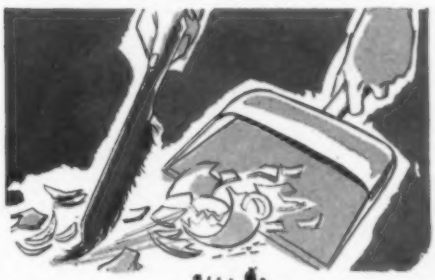
(concluded on page 113)

From an address presented to the Trustee Section of the Ontario Hospital Association, October, 1958. Mr. Dick is a trustee of the Public General Hospital, Chatham.

Why Do Leading Hospitals Insist on DIXIE MATCHED FOOD SERVICE?

From every point of view the installation of Dixie Matched Food Service starts a succession of benefits. It adds cheer and brightness to patients' meals. It reduces unwelcome noise in wards and corridors. It lightens the burdens of nurses and kitchen personnel. Just as important, it materially reduces operating and maintenance costs.

Reason 1: Dixie Matched Food Service eliminates the need for costly purchase and maintenance of dish-washing equipment.



Reason 2: Gone are the crash and shock of broken china and glassware. Dixie Matched Food Service is an attractive single use, disposable service that eliminates shortage and replacement costs.

Reason 3: Dixie Matched Food Service eases staff work, promotes good relations. Trays are 6-lb. lighter, fewer trips to the kitchen are needed; kitchen clean-ups take half the time.

Reason 4: Patients are pleased with the bright, therapeutically heartening colours of Dixie Matched Food Service. They know it's hygenic. They are unafraid of cross-infection and inadequate washing.

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Provincial Notes

British Columbia

Architects Thompson, Berwick and Pratt of Vancouver have sent their plans for the proposed 50-bed Terrace and District Hospital to the B.C.H.I.S. for approval. Planned is a three-storey, T-shaped building.

A bequest of $5,000 has been left to the incipient Lion's Gate Hospital in Vancouver. The money will go towards furnishing three wards of the new institution.

St. Paul's Hospital, Vancouver, is building a new 23-bed interns' residence. The cost is estimated at $168,756.

A new hospital of 26 beds, plus a 5-bed nurses' residence will be erected at Hope. To be named the Fraser Canyon Hospital, the new institution will cost about $445,000.

The village council of Campbell River have decided to buy the Lourdes Hospital building for permanent municipal offices. The Lourdes Hospital had been replaced by the Campbell River and District Hospital a few years ago.

The 53-bed addition and renovation at the Royal Inland Hospital, Kamloops, has reached the sketch plan stage.

Hospital authorities of the Cowichan area have proposed that two new buildings — to give the district 170 more hospital beds— be constructed. Envisioned are a new 140-bed King's Daughters' Hospital, near Duncan and a 30-bed annex hospital at Lake Cowichan—both to be under the same administration.

Alberta

A 100-bed hospital for the chronically ill is on the slate for Medicine Hat. A site has been chosen on the Municipal Hospital grounds and the plans are on the drafting board. It is expected that the building will be ready for occupancy in about 18 months.

Drayton Valley Hospital was presented with a cheque for $961 recently by a neighbouring oil company. The money will provide a new infant resuscitator and aspirator for the hospital.

Proposed for the Innisfail Municipal Hospital in Innisfail is an addition to contain a laboratory, x-ray and emergency rooms and a two-bed ward. Architects are Bissell and Holman of Red Deer. Tenders have already been called for the construction.

At Peace River public support has been given to the building of a new hospital. The old hospital would then be converted into a nurses' residence.

Saskatchewan

At Prince Albert plans for the addition to Holy Family Hospital will add 150 beds and will cost some $2 million. Architects are Webster and Forrester, Saskatoon.

Tenders for the proposed 20-bed hospital at Rose Valley have been called.

Off the sketch board are the plans for the addition to the Kipling Memorial Union Hospital, Kipling. Besides the addition, plans include changes in the existing building, particularly to provide bathroom facilities at the west end, an elevator and an intercommunication system and oxygen piped to each ward.

Ontario

Construction is expected to begin soon on a 72-bed addition to the Owen Sound General and Marine Hospital in Owen Sound. There will also be a new residence and training school for 66 student nurses.

The contract has been awarded for the construction of a 78-bed paediatrics wing at the Greater Niagara General Hospital in Niagara Falls. The new wing will raise the hospital's capacity to 303 beds. Thirty-nine beds in the present children's ward will be moved and renovations will allow 25 adult beds in this section.

The contract for the construction of an addition to Kincardine General Hospital in Kincardine has been awarded. The architect is Douglas E. Kertland of Toronto. There will be two buildings, each with a basement and two storeys. One will be located on the west side, the other on the east. When all work is finished the hospital's bed capacity will have been increased from 44 to 78.

The London District Crippled Children's Treatment Centre, connected with the War Memorial Children's Hospital, is nearing completion in London. All facilities for out-patient and in-patient investigation and care will be provided at the Centre. There will be a nursery school and day school, outside play therapy, water therapy, physical therapy, occupational therapy, hearing testing and speech therapy units. The Centre has been built so that it can be expanded by six floors when necessary.

A 92-bed wing for non-tuberculosis patients has been opened at the Essex County Sanatorium, Windsor. To further meet the bed need in this city the Hotel Dieu is planning to build a 264-bed addition and the Metropolitan Hospital has plans for another 60-bed unit.

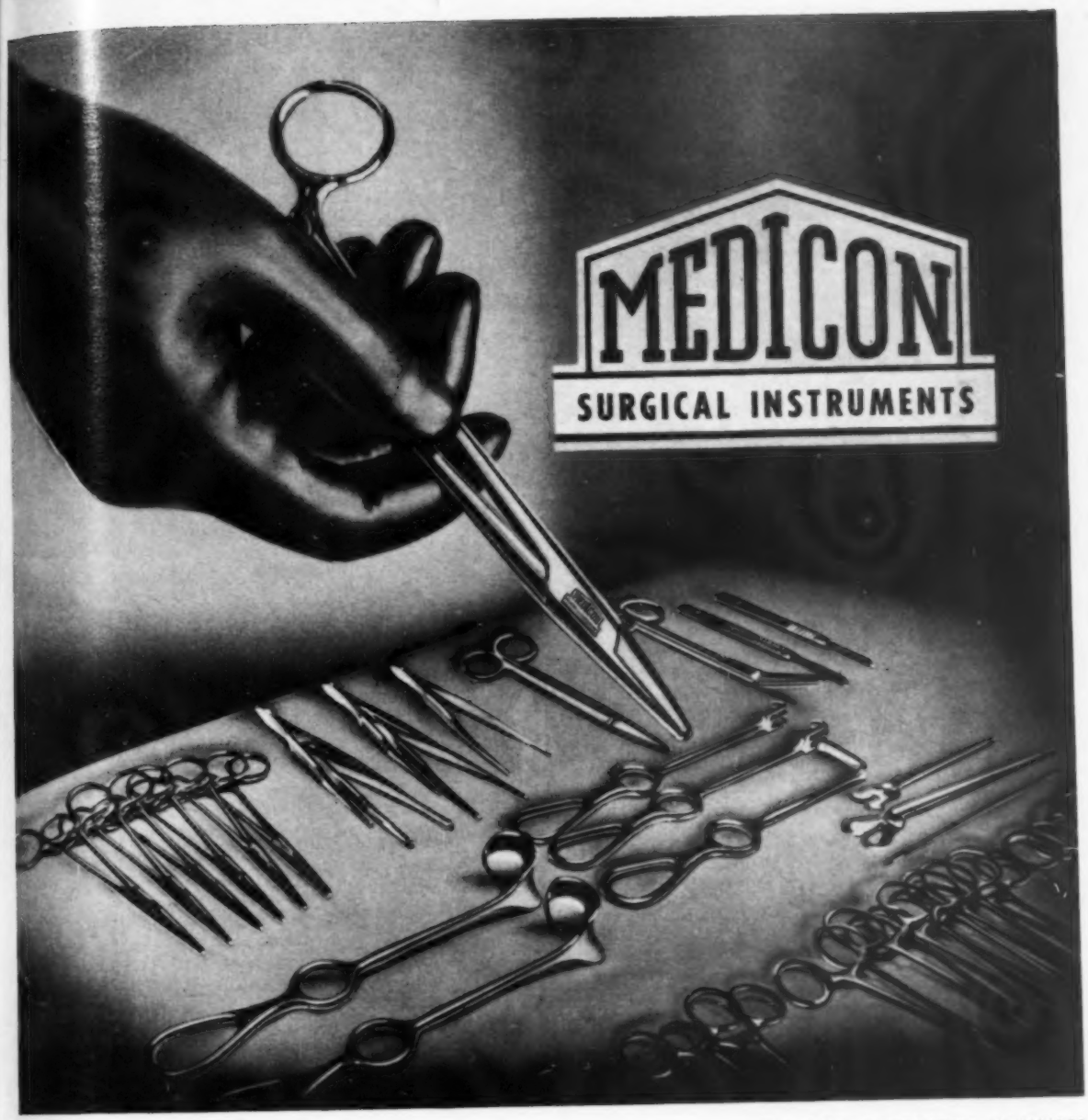
A new entrance, metal and glass outside doors, new stairs, acoustic tile work and washroom are among the plans in renovations to the emergency and administration building of the Toronto General Hospital (College Street). The Dunlap building, on University Ave., one of the original parts of the hospital is being demolished to make way for the entrance to the new main wing, which was recently opened. Architects for the project are Mathers and Haldenby, Toronto.

The cafeteria in the new extension to the Ross Memorial Hospital, Lindsay, is to be increased to double its capacity. The estimated cost of this proposed alteration would be about $5,000.

Tenders for contracting have been received for the two-storey addition to the McKellar General Hospital in Fort William. Architects for this expansion are McIntosh and Associates of Fort William.

Ottawa plans to have a separate, self-contained 135-bed children's hospital within a year. Plans to renovate and convert the East Lawn Pavilion at the Civic Hospital, built in 1953 for communicable disease cases, are on the boards for this purpose. The new hospital will increase by 50 per cent the present 90-bed paediatric ward at the Civic; it is to be linked with the main hospital by tunnels and will mean new partitioning, provision of a family room and playrooms.

(concluded on page 74)



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Provincial Notes

(concluded from page 72)

The governors of the Welland County General Hospital received a pleasant surprise when they learned that a well-known public figure in Welland had willed the hospital a fifth of his estate. The bequest, its exact figure still unknown, will probably go towards the building of a new nurses' residence.

Gladys J. Sharpe of the Ontario Hospital Services Commission wielded a spade to turn the first sod for the new Edith Cavell nurses' residence at the Toronto Western Hospital. This building is the second phase of the hospital's expansion program, and will provide accommodation for 112 additional student nurses. Also scheduled is construction of a third new unit to be called the Bathurst building which will house the new main entrance and the emergency and admitting departments.

The new wing at the Kirkland and District Hospital, Kirkland Lake, is in full use now that all the children have been moved from the old nursery into the bright new rooms on the second floor of the new structure. The reception station and general floor of the wing have been in operation for some time.

North York's Branson Hospital marked its second birthday recently — right in the midst of building an addition which will double its completely filled 90-bed capacity. Larger emergency and x-ray departments—the latter now has a second machine given by the Atkinson Charitable Foundation—and a new paediatric wing will also result from the expansion.

Architects Balharrie, Helmer and Morin, Ottawa, have finished the plans and the contracts have been awarded for the 90-bed addition to Perth Great War Memorial Hospital, Perth. Also in Perth, to be started this year, is a $3 million infirmary for mental patients.

Construction of the nine-storey 230-bed addition to St. Mary's Hospital, Kitchener, will start next spring, tenders being called early in 1960. The new facilities will increase the hospital's capacity of 122 and will include much needed new equipment. Total estimated cost is $4,200,000.

A summer start has been given the 20-bed addition to St. Mary's Memorial Hospital in St. Mary's by having the tenders for construction called. Architects are O. Roy Moore Associates, London, and the plans picture a one-storey building with basement and brick exterior, estimated at a cost of $250,000.

Kingston General Hospital, Kingston, has undertaken a renovation and extension of its dietary building where a new cafeteria is to be constructed. The Connell Wing is also nearing completion.

In Barry's Bay, a new two-storey hospital — to be called St. Francis Memorial Hospital — is about to rise. Recently the first sod was turned for the building which will accommodate 36 beds.

A new Ontario Hospital is to be erected east of Owen Sound soon, according to a recent announcement from Queen's Park.

Quebec

Dignitaries and citizens turned out to applaud the first sod turned on the site of the new hospital to be built at Amqui. This new institution is to have 75 beds and is to be run by the Soeurs de l'Espérance.

Hôpital Jean Talon, one of Montreal's youngest hospitals, will soon have 450 beds. Work is now under way on the ten-storey building to incorporate a residence for 14 interns, a new nursery, a chapel, a meeting room, a kitchen and dining rooms as well as a new department of surgery and paediatrics.

Tenders have been called for the new residence at Hôpital Notre-Dame de Chartres at Maria in the Gaspé area. The three-storey, brick walled building, designed by architect Pierre Rinfret, Quebec City, is expected to cost about $400,000. The hospital is run by the Sisters of St. Paul de Chartres.

An artificial heart-lung machine has been presented to the Montreal Children's Hospital, Montreal, by the Junior Red Cross Committee. Over 50 teen-agers gathered at the hospital to watch the presentation of the apparatus to Dr. David Murphy, surgeon-in-chief, for it was by their efforts at fund raising in 28 Montreal high schools that the gift to aid young patients in open heart surgery was made possible.

A new wing, costing some $450,000, for the Hôtel Dieu St-Vallier in Chicoutimi is going up. The four-storey structure has been designed by Desgagne and Coté, Chicoutimi.

New Brunswick

A 150-bed extension is proposed for Moncton Hospital. A wing attached to the existing infirmary would provide services on the ground floor and patient accommodation would be found on six more floors. The delivery room would thus be enlarged, the out-patient facilities, the operating suites, the nursery and the physiotherapy would have more room as well. All plans, the hospital hopes, should be complete so that construction can start in May of 1960.

Nova Scotia

Renovations to the former tuberculosis hospital in Halifax have been completed and no further delay is anticipated in turning this building into the Halifax Convalescent Hospital. The hospital will have space for 55 beds and will require about 15 more nurses to staff it.

The Bayview Hospital in Advocate Harbour is still closed for want of a resident doctor. The 10-bed institution, one of the first Red Cross out-post hospitals in the province, has not been operating since 1958.

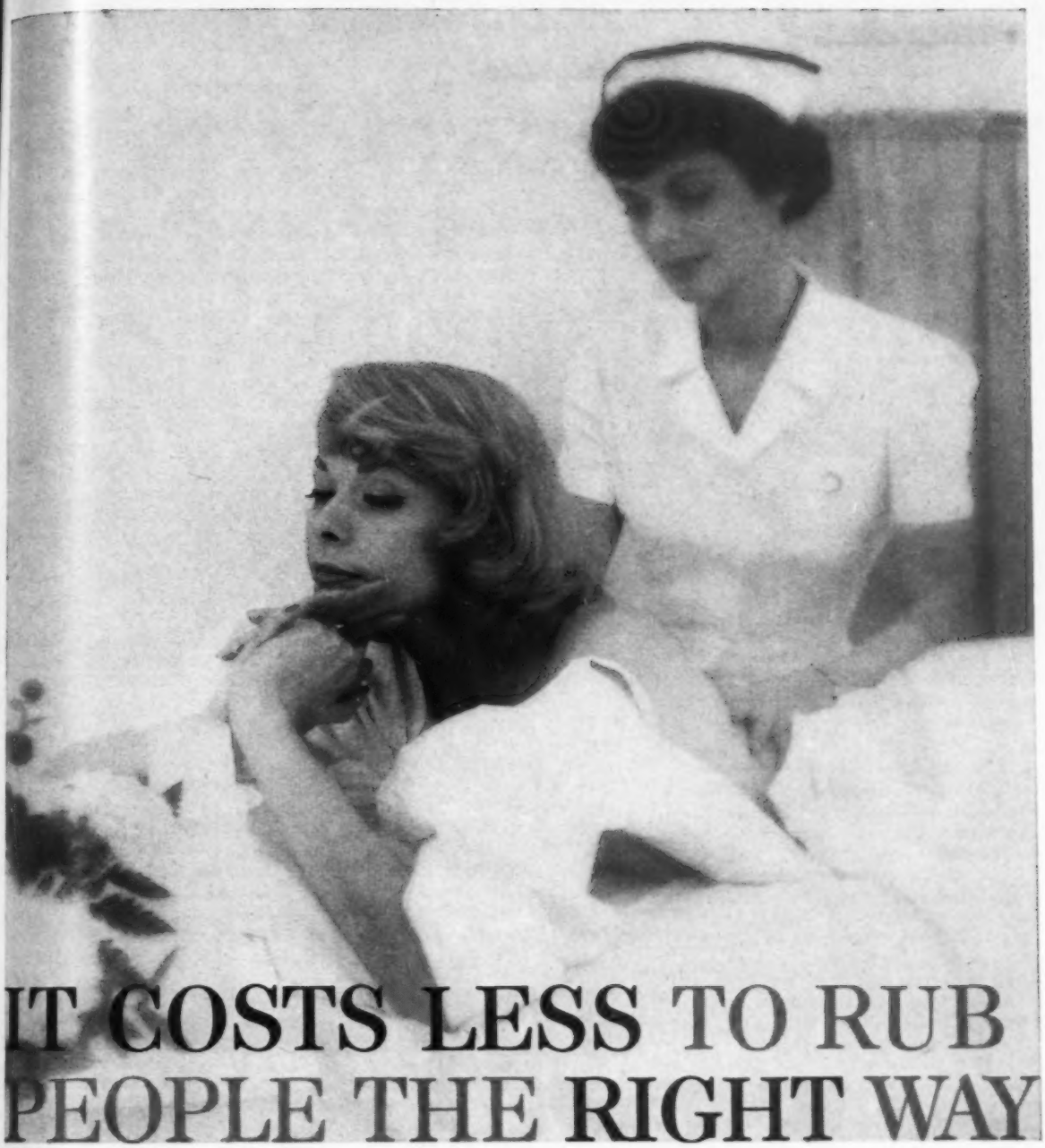
Heroism among staff and patients at the No. 5 pavilion of the Nova Scotia Sanatorium in Kentville averted a heavy loss of life when fire broke out and raged through the building recently. Cause of the blaze has not been determined although it is suspected that mattresses stored too close to steam pipes might have been ignited. Damage estimated at $50,000 was incurred before the local fire department subdued the flames. All the patients were evacuated and given quarters in other buildings on the grounds.

Plans and specifications for a new hospital in Springhill are now before the hospital board. The new 65-bed modern, three-storey structure is expected to be located just south of the present hospital.

Nursing Fees Go Up

Nursing fees in Toronto, Ont., have been increased by $1 a day. As of May 1, 1959, the fee for medical, surgical, obstetrical and isolated cases is $15 a day (for an eight-hour day). For a ten-hour day the fee is $17.

If there is more than one patient in the house, $5 for an eight or ten-hour day is charged for every extra patient.



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With the Auxiliaries

A Question of Morale

Morale is an all-important quality, even a life-saving quality—and women's auxiliaries can help fortify the morale of patients. A kindly gesture, a thoughtful and sincere inquiry, a smile, a joke or a friendly "Here's my hand, let me help you" can do much to bolster drooping spirits.

This is what we* have tried to do at Ongwanada Sanatorium. Its Indian name means "our home", and its auxiliary members do everything they can to bring the comfort and warmth implied in the name to all the patients in the hospital. Indeed, they feel that the sanatorium is the finest in the country, probably the finest on the continent, possibly the finest to be found anywhere. They know no other sanatoria; but they cannot imagine another more lovely than Ongwanada.

It was not always a beautiful building. The large rambling frame structure, on spacious grounds, once had a barn-like interior, with drab greens and dull beige in the long corridors and wards. Three years after the second world war, the building, then a military hospital, was purchased by the East Central Counties Tuberculosis Association, and in August of 1948 Dr. Bruce Hopkins took over as medical director and administrator of the sanatorium. Because he himself has suffered from tuberculosis, he is able to understand the psychological and emotional needs of the patients as well as their physical problems.

First of all the hospital had its face redone. The long, tunnel-like corridors are now bright with gay wallpaper and light paint. The main lounge has become a room of great beauty and comfort, a room always available for the patients' use. The dining room is large, airy and attractive, with small tables and snowy white tablecloths. There are flowers everywhere (they are grown in the greenhouse on the grounds), and colourful and interesting murals decorate the dining room and lounge. Most of this work was done before the auxiliary was formed six years ago. Our task has been to help carry out a program begun before our arrival.

This is a big task and there is much for us to do. Lovely furnishings alone cannot erase the morale problem, although a cold and dismal environment could make everything seem worse. Patients, after all, must remain in the sanatorium for quite a long time and often they have not been prepared for it. Home, business and personal relationships have been thrown into confusion. And then when they come to the hospital their freedom is greatly restricted. One can understand their depression, their loss of enthusiasm.

Devoted auxiliary members who come to the hospital regularly help prove to the patients that they are not forgotten and convince them that the hospital is deeply concerned with their welfare and interests. New patients soon learn about the auxiliary through the patients' council. They find that we are always ready to supply various items for their comfort and entertainment; our visits themselves are helpful. And the treats that we bring—fruit, candy, tobacco—give them something else to look forward to.

Sometimes, expensive articles such as television sets, radios and other electrical appliances are provided by the auxiliary. These are continuing evidence that the auxiliary has the patients' interests at heart. And in 1957 the chapel was enlarged and completely refurnished. It is now a beautiful room filled with comfortable chairs which are a boon to the older patients. At present we are working to set up a blood clinic for the hospital.

At Ongwanada, then, there are endless opportunities for us as auxiliary members to help build up the morale of the patients. We do not claim that we are 100 per cent successful all the time. But when we hear ex-patients talk about the sanatorium and its auxiliary, and when we see ex-patients helping out generously in our projects (ex-patients are our best public relations agents) our reward is great. We know then that we are doing our job.

From a paper given by Pauline Platt, Kingston, Ont., at the convention of the Women's Hospital Auxiliaries Association of Ontario, October, 1958.

Two Years of Service

Although the Grace Dart Hospital was established in Montreal in 1898, it has had a women's auxiliary for only two years. The ladies have achieved a great deal in this short time. Their first fund-raising event was a card party and their first contribution to the hospital nine lawn chairs for patients. Then the auxiliary had the patients' lounge redecorated and later supplied every ward with a television set. They have also given the hospital a new refrigerator and a much-needed stretcher.

A sewing group meets regularly to make masks, pyjamas and nightgowns. Additional furniture for the bedrooms has been supplied and several books have been added to the hospital's library.

The auxiliary has more big projects planned for the future. They want to begin an occupational therapy program for patients, and hope to have a special room set aside for the work.

Small but Successful

Much time and good will have been donated by the North Kamloops and District Auxiliary of the Royal Inland Hospital in Kamloops, B.C. Its members have furnished two four-bed wards in the hospital. They have also provided several pieces of equipment—two wheel chairs, two oxygen tents, a suction pump, and so on. Each year the auxiliary holds a linen shower and each year Christmas gifts are handed out to patients.

How do the members raise the money? They sell plants and home cooking. They hold teas, whist parties and raffles. Every June there is a birthday party. A "birthday box" is passed around and each member contributes according to her age. In November, the regular meeting becomes a talent night—each lady brings something she has made. Then other members purchase the items. The proceeds are used to buy Christmas gifts for the patients.

Bottled Brains

"Golly, this liniment makes my shoulders smart!"

"Why don't you rub some on your head?" — *Davis' Nursing Survey.*

Modern way to combat the fourth largest cause of hospital fatalities

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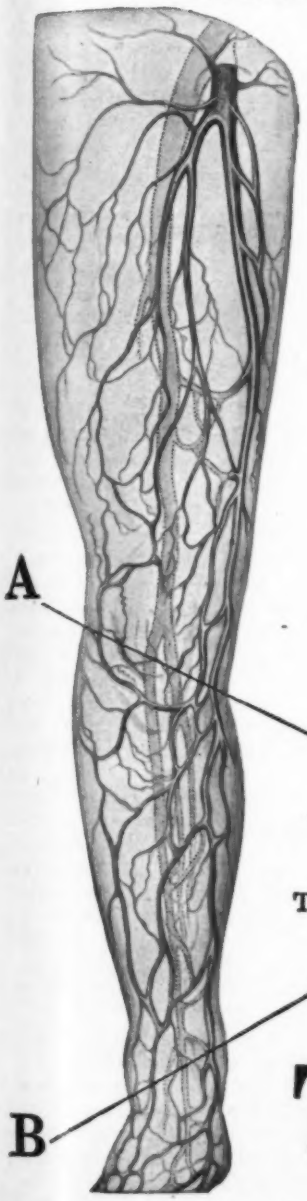

A to B indicates common origin sites of Thrombo-Embolic Disease.

Pulmonary embolism today ranks fourth in incidence of hospital fatalities (perhaps it would be even higher if the cause of death were not often attributed to the accompanying disease).

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Notes on Federal Grants

Construction

To assist in the construction of the Southey and District Health Centre, Southey, Sask., the federal government has granted $7,958. In the new centre there will be one recovery bed, an out-patient department, dentist's office and a public health area with accommodation for two public health nurses.

New headquarters for the entire Peace River health unit will be built at Dawson Creek, B.C. Office accommodation for six public health nurses, the medical director and one sanitary inspector is to be included along with space for holding public health clinics, meetings and lectures.

Some $7,563 goes to the Burns Lake Health Centre in Burns Lake, B.C. This new centre will have space for a clinic room with three nurses' rooms, an x-ray dark room, a medical supply room, a general office, a conference room, and office space for volunteer agencies and a sanitary inspector.

Some $1,029,813 has been granted to the Verdun Protestant Hospital, Verdun, Que., for renovations and additional construction. Space for a 150-bed unit for medical-surgical cases, with diagnostic and therapeutic facilities, a 100-bed unit for convalescent patients and a 26-bed addition to the nurses' residence are all being planned.

The Hôtel-Dieu St-Vallier, Chicoutimi, Que., will receive $181,700 to help with a renovation project to improve nursery, obstetrical and paediatric facilities. More space for urology, cardiology and a laboratory is scheduled, and the hospital hopes to add new departments of dermatology and allergy.

For expansion and renovation of St. Mary's Hospital in Montreal, Que., some $177,293 will be granted. An additional six beds as well as increased facilities for out-patient and nurses' training are to be provided.

The Toronto Western Hospital, Toronto, Ont., will be assisted with $64,753 towards a major renovation project. The project, now underway, will increase floor area for all departments and improved organization and traffic flow for the out-patient, emergency and admitting departments will be effected.

Some $66,610 goes to Alberta for the construction of a new Cancer Clinic Building at Calgary. The new clinic, adjacent to Holy Cross Hospital will meet the needs of the entire southern half of the province.

A new nurses' residence will be built at the Provincial Mental Hospital, Ponoka, Alta. The new building, to house 70 beds, will receive a grant of $52,500.

A grant of $67,433 will help in building an addition to the hospital at Melfort, Sask. Space will be provided for a board room, staff lounge, dispensary, public health facilities, major and minor operating rooms, supply room, doctors' lounge, medical records, offices, solarium, an emergency out-patients' treatment room, and 33 more active treatment beds.

The Rose Valley, Sask., Union Hospital gets $46,953 in federal monies to aid in its construction. The new hospital will have 20 beds, seven bassinets, and related facilities such as operating room, case room, x-ray and laboratory and out-patient department.

A new health centre at North Battleford, Sask., will be built with federal assistance amounting to $29,413. The new, two-storey structure will be fully air-conditioned and will house a clinic and conference room, examination room, nurses' area and offices for the regional medical health officer, psychologist, health educator, nutritionists, dental clinic, sanitary officers and a general office and reception room. It should be ready for occupation by November.

Education

New equipment for an extension of the school of nursing at Hôtel-Dieu de Québec, Quebec, Que., will be bought with the help of a $12,329 grant.

A $29,203 grant goes to the school of nursing, recently established at the University of New Brunswick, Fredericton, N.B. The money will help in buying equipment needed for the basic courses in elementary biology, physiology, anatomy and microbiology.

Diagnostic and Research

The Mountain Sanatorium at Hamilton, Ont., will receive $9,150 for tuberculosis control. It will go to further studies on the use of radio-active isotopes in rapidly determining pulmonary function. Under the direction of Dr Paul Rabinowitz, of the ear, nose and throat department, the research is expected to result in the development of simple, rapid pulmonary function tests to be used in assessing operability in chronic lung disease.

A grant of $9,814 has been awarded to the Research Institute of the Hospital for Sick Children, Toronto, Ont., to carry out work on studying the Powassan virus. Dr. Donald McLean, director of virology, will head a group working to learn more of the virus' means of maintenance and transmission so that further infections may be prevented.

To conduct studies on the effects of dust on the respiratory system and the development of methods of treatment, $28,545 has been granted. The project is being conducted by Dr. E. Robillard, director of physiology, University of Montreal, who will be assisted by a special consultant, Professor Lucien Dautrebande of the University of Liege and Berufsgenossenschaft Clinic, Bochum.

The University of Ottawa will be given $10,155 to aid in a research project under Dr. William F. Barry, assistant professor of psychology. The project will be conducted at the Ottawa General Hospital, the School of Psychology of Ottawa University and the Ontario Hospital at Brockville, Ont.

Public Health

The school of nursing at the Hotel Dieu Notre-Dame de Beauce, St. George Ouest, Que., will gain more equipment and be enlarged with the aid of a $13,312 grant. A construction grant of $55,333 also goes to the hospital for building a new two-floor addition to the nurses' residence.

A public health grant of $15,843 awarded to the School of Nursing of the Hôpital St-François d'Assise, Quebec City, Que., will help in the purchase of technical and scientific equipment for the various laboratories of the school.

C.S.L.T. Annual Meeting Held in Calgary

Membership Classification Expanded

AT its annual meeting in Calgary in June, with Jessie Hudson of Vancouver presiding, the Canadian Society of Laboratory Technologists adopted a revision of its by-laws. It has thereby provided for an expansion of membership, the establishment of special interest sections, and a certification board.

Under the expanded classification, membership will now be possible to all workers in the medical laboratory field. This, it is hoped, will facilitate sharing knowledge and skills and maintaining a high standard of laboratory work. The sections provided for in the revision are to be developed according to the various science disciplines which form the basis of medical laboratory technology. Technologists with a specific interest in one phase of medical laboratory work—biochemistry, microbiology, serology, histopathology—or in a highly specialized skill such as histologic technique, might arrange more opportunities for meeting of members within the group. Those whose interest is the general medical laboratory field, so important in the medium and small sized hospital laboratories, will be afforded more opportunity to present and solve their special problems when they meet. Those with advanced knowledge in their field will be able to share it with others and contribute more effectively to the maintenance of high standards in laboratory work. Newcomers will find more chance for improving skills and broadening their knowledge of laboratory science.

Local academies, regional branches, or other agencies sponsoring scientific programs, workshops, seminars, refresher courses, et cetera, could have available much valuable consultant service and source material through these special interest sections. It is hoped that credits for participation in such programs will be acceptable towards higher levels of certification. Each section will be asked to keep under continual review the part of the C.S.L.T. syllabus pertaining to that phase of laboratory work.

The certification board is being set up to bring into closer collaboration those who prepare the C.S.L.T. syllabus, those who train candidates to qualify for C.S.L.T. certification, those who set examinations and those who preside at and mark the examinations.

Following is a list of those on the certification board established in Calgary. "SS" indicates that Science Sections will be asked to make nominations for succeeding appointments to these posts. In the future three appointments will be made each year to maintain the board.

To hold office to the end of 1960—Jacob Berger, Regina; (SS) Margaret Erskine, Vancouver; (SS) Deborah Haight, Ottawa.

To hold office to the end of 1961—Jean Matheson, Edmonton; (SS) G. Fearnehough, Toronto; (SS) Claire Larocque, Montreal.

To hold office to the end of 1962—David Epp, Vancouver; Harold Amy, Hamilton; and Archie Shearer, Vancouver.

Members will find more details of these developments in the "Schedule of Notice to all Members with Reference to Amendments to By-Laws" which accompanied the call to annual meeting, in the reports to the annual meeting of the Legislation and Standards Committees, and in the minutes of the annual meeting which will be mailed to all members.

Elected to the 1960 executive were: *President*—Roy Uttley, Kitchener, Ont.; *Immediate past president*—Jessie Hudson, Vancouver, B.C.; *President-elect*—Olga Lange, Regina, Sask.; *Vice-president*—Jacob Berger, Regina, Sask.; *Directors*—Guy Colprom, Montreal, Que., Hilda Fleming, Winnipeg, Man., and Leslie Mellor, Sudbury, Ont. *Secretary* is Nona Bruce, Toronto, Ont., and *Treasurer* is Gordon Traill, Pembroke, Ont.

Among the papers given during the scientific sessions were many which provided real stimulation to the delegates. Twenty commercial houses displayed the newest in equipment and methods and the social highlights included the annual banquet and a real western barbeque.—*Released by Ileen Kemp, executive secretary, C.S.L.T.* ■

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Of course, dirty ducts are only a *part* of the cleanliness picture in the hospital. Everyone knows that hospitals are scrubbed clean many times a day. But to effectively combat this important *airborne dirt* problem—and make your ventilating air and air conditioned air as clean as possible—you can depend on the Honeywell Electronic Air Cleaner.

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H HONEYWELL *First in Control*

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Morbidity Studies

(concluded from page 50)

exist, there should still be some way of knowing what kinds and qualities of care the patient receives. Desire for such information also applies to expenditures of any prepayment agency which in the case of the British Columbia Hospital Insurance Service now amounts to a yearly expenditure of $42 million for current operation alone. The federal government will also wish to know if it is receiving proper value for expenditures under the new hospital scheme, and has already indicated its desire to develop some sort of evaluation program.

Studying Special Groups

A special application of morbidity statistics will be the study of groups such as Indians and recipients of War Veterans' allowances, which have always presented special hospitalization problems. Comparisons between provinces of their experience with these sections of the population could bring certain characteristics to light and improve their treatment.

Proper Accounting

In any undertaking where revenues are raised and funds are expended, the agency responsible for these activities will expect a proper accounting of the undertakings involved. Federal and provincial treasury boards will expect the various hospital schemes to be able to explain in a satisfactory manner how their funds are being spent and, in some instances, how the money is being raised. No doubt the financial problem of raising money to support the various hospital schemes will attract the most attention in the program's early stages. However, probably the most difficult problem in the long run will be keeping the program in line with the willingness and financial ability of the subscribers to pay; that is, the general public. This involves much more than the financial field and takes in the medical care field as well. Vague and intangible phrases such as "a high standard" and "a good quality of care" are not likely to appease the enquiring financial group if and when the actual expenditures far outstrip estimated revenues—as has been the case in the majority of government sponsored hospital schemes in the past. It is doubtful if the financial experts will be satisfied to be told that so many patient days were supplied the public during the year without also being informed of the type of days they were. In other departments, if the government were to buy a thousand cars, it would want to know not only the actual number delivered but also what kind they were.

The analysis of morbidity statistics can do much to throw light on the many problems in hospital administration, and it can reflect the trends of disease—its incidence and the influence which new medical procedures can have on that incidence. However, before embarking on costly schemes to collect material which would reflect these things, it would seem essential that we first assure ourselves that the source of our material is accurate and, therefore, worthy as a basis for research and control measures. Secondly, we must be sure that when the material has been developed it will be acceptable and will be used by those persons for whom the data are collected and analyzed.

There is almost no limit to the amount of money that can be spent on medical care but this must be kept in balance with other services in our society. Nevertheless, the public has indicated in no uncertain terms that it expects medicine to keep pace with other fields of science and the hospital is the place where a large part of these new medical services will be provided. It seems the hospital will be faced with the problem of providing an increasing volume of service at uneconomic rates with every new advance in medical science.

It is interesting to note that in the United States one item in the consumer price index that showed the largest percentage increase from 1936 to 1956 was hospital room rates, rising 264% during that period. It is estimated in the United States now that these rates will go up a further 20%-25% in the next 2½ to 3 years. This is understandable when one considers the high percentage of labour in hospital service as compared to the usual product of industry. In hospital service, labour is responsible for from 70%-75% of the total hospital costs, whereas in industry it is usually about 40%. Therefore, an increase in the general wage level has almost double the effect on hospital service cost as compared to that of the industrial product. Further, it is only possible to apply automation principles to a very limited area in hospital operation since every patient presents an individual problem which will not react in a sufficiently uniform manner to treatment programs to permit the use of the mass production methods of modern industry. Instead, it has been found that where new pieces of equipment have been purchased to provide a new service or improve an old one, this has, instead of reducing staff, often resulted in the employment of additional personnel with higher and more costly qualifications. However, the factor having the greatest influence on hospital costs is the type of medicine practised in the hospital. It is primarily responsible for the increased staff and equipment experienced in recent years. That is why it is so important to know what type of service is being supplied by the hospital. Morbidity statistics supply the basic data for the study of some of these problems.

Quantitative analysis, with resulting control of budgets, bed construction and extension of services, is one side of a sound hospital care program. The other is that of qualitative control and professional evaluation. The latter field is one in which comparatively little work has been done to date, and problems in this field, which are now becoming apparent, must be solved in the future. The people will undoubtedly demand that the standard of their hospital care keep pace with advances elsewhere. They will want to know how much and what kind of hospital care they are receiving. Evaluation measures to accomplish this must be developed in the near future. ■

About Style

Writing is not a hallowed mystery, remote and secret. The ability to express ourselves is not a frill for the edges of life, but an indispensable tool of our self-understanding, our understanding of others, and our rational contact with the world around us.

A certain unaffected neatness and grace of diction are required of any writer merely as a matter of courtesy. But a genuine style is the living body of thought, not a costume put on for a special occasion. One doesn't need the verbal music of Shakespeare, but one must be able to make a pattern out of a muddle and build up a certain unity of matter and manner.—*Monthly Letter.*

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GENERAL ELECTRIC

The Trend is Upwards
(continued from page 56)

establishment of admission and discharge committees, pharmacy committees and diagnostic services committees. The existence of these committees, provided, of course, that they function as intended, should do much to ensure control.

Presuming that we can control hospital admissions to the point where only those who really require the facilities of a hospital obtain a bed (This is our day to be optimistic!) we still have the trends to contend with, and the future will be here before we know it. What are we doing to meet the changing needs?

Since the Ontario Hospital Services Commission established its Department of Research and Statistics, we have been assisted in studying trends of use. As a result of our studies of individual hospitals by residency of patients we have learned something about our bed needs. In the past we have operated on the theory that an average of five active treatment hospital beds for the province as a whole was about the norm, and this rule of thumb has been generally applied in each community throughout the province. However, with the greater, detailed information now available to us, we find that, community by community, this average does not hold true. In the small community hospital there are limitations of facilities and of specialized personnel. Actually, our studies indicate that the small community hospital can treat only about 65 per cent of its community's hospital cases. Most of the remainder of the community are treated in a nearby larger centre in what we will call a district hospital. This larger hospital treats about 85 per cent of the hospital patients in its own community, along with a proportion of the surrounding communities' referrals.

We come now to the regional or base hospital which is found in the larger centres in Ontario. This is a teaching type of hospital which is required to meet 100 per cent of its own community needs; in addition, it provides for referrals of a more specialized type which cannot be cared for in either a community or a district hospital. On the basis of our research findings and analyses, it is our belief that four beds per 1,000 would probably be sufficient in our community hospitals—four and a half beds per 1,000 in our district hospitals, and, five and a half beds for a regional centre such as Toronto.

Then there would be five beds per thousand people available on a provincial basis. However, the beds, and the type of beds required, will have been made available where they will be used. Thus people residing in the smaller community will have access to five beds per 1,000 but only four of these beds are at their local community hospital; another half bed per 1,000 is available at the district hospital and still another half bed per 1,000 is available at the base or regional hospital.

This brief resumé, which I have endeavoured to simplify as much as possible, seems to us to show a more realistic approach to locating the beds in the communities where they are needed most.

Our studies, moreover, indicate that as the ratio of hospital beds to population increases so does the demand for beds. One important reason for this is the criteria a doctor uses to determine whether or not his patient should be admitted to hospital change. With a *shortage* of beds the doctor would often recommend treatment at home. With an *abundance* of beds, if there is any indication at all that the patient might do better in hospital, the doctor will so recommend. I do not mean this to reflect at all upon the integrity or the judgment of the medical profession. I believe it is just the way any one of us would react under the same conditions. We, too, would want the very best care available for those who look to us to prescribe the treatment. Not long ago I had a conversation with an official of the British Health Insurance Scheme. He told me the number of beds per 1,000 was deliberately held to an average of less than three. Surely this would be one way to assist the doctors to come to their decision of whether or not Mr. Brown or Mrs. Jones should be admitted to hospital.

Again, in studying trends in use of hospital services in Ontario, the Commission recently conducted a county by county survey throughout the province. It became very obvious to us that where the shortage of hospital beds was most acute, there was also, in most cases, a shortage of custodial or domiciliary facilities. We think this is a significant confirmation of the fact that our hospitals are being stifled in the execution of their real responsibilities by having to provide accommodation for patients who do not need all the facilities of our high-cost hospitals. This is a waste of expensive specialized accommodation and services. Furthermore, it is unfair to the patients themselves, for it has been proven that, placed in the proper type of accommodation, many of our so-called chronic patients are being rehabilitated. The very fact of being in accommodation intended for the very ill, has a tendency to increase the invalid complex. Conversely, if these people are cared for in institutions where at least some of the people are up and around, they have a tendency to try to do more for themselves and get a little more enjoyment out of life.

As we study the hospital bed needs for Ontario, we are becoming persuaded that we have sufficient active treatment beds in many areas of the province, if we could but transfer the long-stay patients into appropriate lower cost accommodation. However, one of the great advantages of a province-wide prepayment system is, that for the first time, we will be able to assess intelligently, not only how much accommodation we require, but exactly what kind of accommodation is needed in each particular area of the province.

From what we have learned so far, it has become obvious in Ontario that we need more homes for the aged and a system of *public* nursing homes. I think that the rôle the homes for the aged are playing in the care of bed-ridden, or partly bed-ridden senior citizens is especially important since these homes are providing some low cost infirmary care. In the future these homes and the type of service they provide will become infinitely more important in the care of our incapacitated citizens.

Much has been said about the value of hospital-based home-care programs. Is enough being done in this study and development? I, for one, certainly feel that this is something we should explore very seriously as a means of shortening the length of stay in our active treatment hospitals and making precious beds available to those who need them.

The trends are ever upwards. Hospitals have never been so important in the life of our people, the financial problem of hospital

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The Trend is Upwards

(concluded from page 86)

operating costs is rapidly receding, and we still have problems. In reaching for solutions we are striving for an ideal, but despite our great desire to roll up our sleeves and do something about our difficulties, we must first know what are our true needs in facilities and personnel in our own areas. By study and evaluation of the trends in the use of services, answers may be found.

And to close, may I quote a paragraph which the *Canadian Hospital* published from the works of the famous Arnold Toynbee:

"My own guess is that our age will be remembered chiefly for having been the first age since the dawn of civilization in which people dared to think it practical to make the benefits of civilization available for the whole human race."

If we believe this, then it is our responsibility to make hospital care—one of the truly great benefits of civilization—available as economically and efficiently as possible. ■

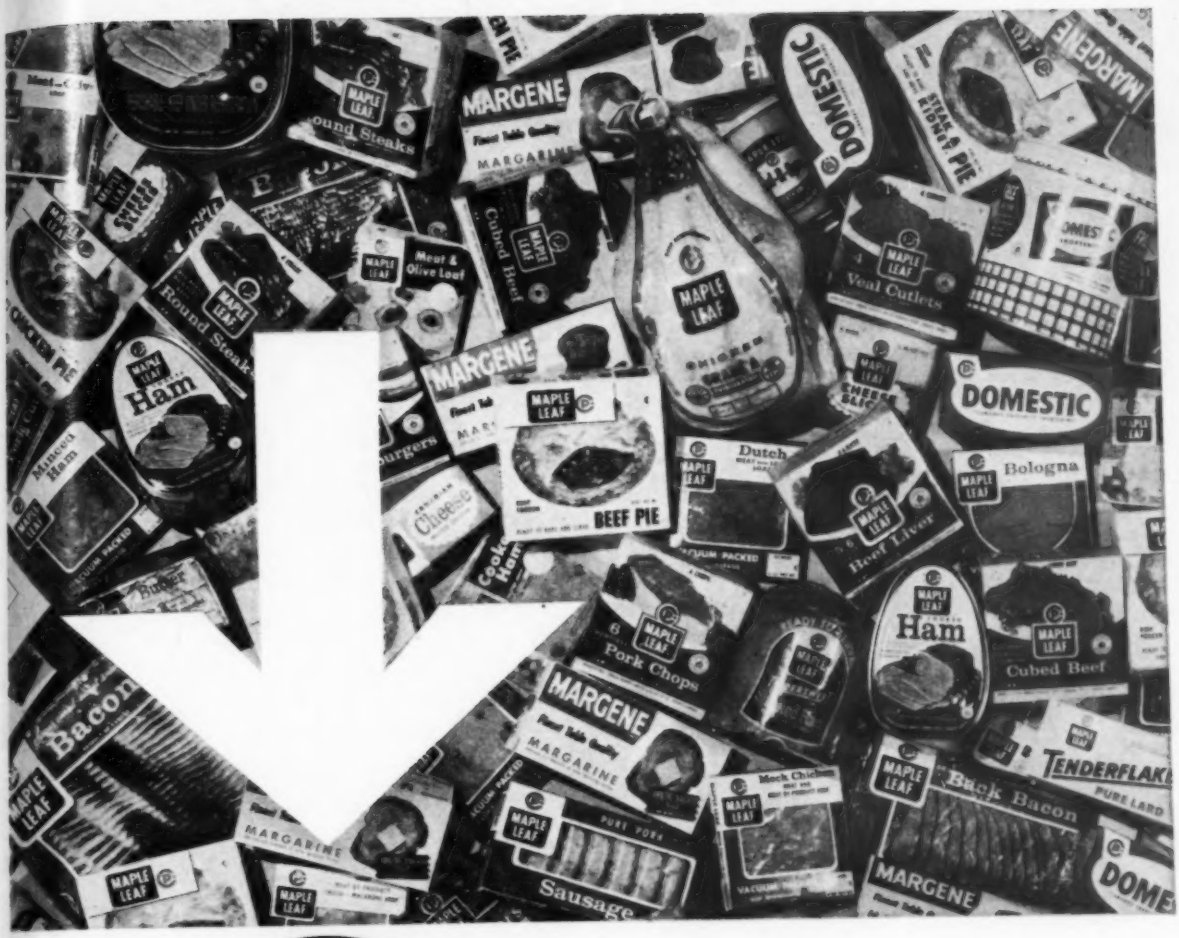
Pollution Problem

"If gas masks are not to become as common in a hundred years as shoes are today, we should do well to heed our somewhat submerged instincts of self-preservation and remember that — whatever other uses man may devise for it—air is still essentially for breathing." This statement was made by Dr. James P. Dixon, commissioner of health of Philadelphia at the National Conference on Air Pollution which was held in Washington, D.C., last November.

The conference revealed that air pollution is indeed a serious problem, but it also pointed out that there are possible solutions to that problem. Measurement of air pollution shows that the cleanest air is desert air. Mountain and forest air is twice as polluted as desert air and farmland air is three times as polluted. Even the cleanest air in cities is five times as dirty as the air in any non-urban area. This paints a rather black picture for the city dweller. A number of deaths have been attributed directly to air pollution and the rise in deaths among city dwellers from such diseases as emphysema and lung cancer gives further cause for alarm. However it was also pointed out at the conference that extensive research is being carried out to combat pollution. In industry, for example, recovery of a saleable by-product from the air has solved pollution problems in many cases. Leftovers from antibiotic production are now added to animal feed supplements; one company recovers liquid chlorine from air-chlorine mixtures at a cost of about $19 per ton compared to a market price of over $60 per ton; and a market is developing for fly ash from coal burning. Perhaps someday an effective weapon will be found and air will be pure again. Until then, air pollution must be regarded as a dangerous enemy.

Kellogg Aids Accounting in U.S.A.

A grant of $81,890 was made to the Hospital Research and Educational Trust from the W. K. Kellogg Foundation, to help small hospitals improve accounting procedures and to provide better financial and statistical information to hospital administrators and trustees. The grant will finance the Hospital Administrative Services project (which is to last four years) of the Trust in Colorado, Nebraska, and South Dakota. Expansion will include larger hospitals and hospitals in other states.



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CANADA PACKERS

PLEDGE OF FINEST QUALITY

Oshawa General Hospital

(concluded from page 47)

and two assistants, the superintendent's office which doubles as a board room, telephone operators, gift shop, business manager, accountant and general accounting staff.

A school of nursing with a separate class room building has 83 student nurses. The school program is carried on by a director of nursing education and a staff of six specialists. Two nurses' residences house 100 people.

Oshawa General Hospital has not forgotten its older sections—here renovations have recently been completed. The entire area now has a sprinkler system in each room, acoustic ceilings have been added, piped oxygen is available to each bed, there are the ceiling type of bed curtains for each bed, the nurses' stations have been enlarged, the washrooms have been enlarged and remodelled, wall-type bed lamps have been provided for each bed, and the whole area has been repainted. The electric wiring, too, has been completely replaced. And, as an added touch, a student nurses' conference room has been established on each floor. The main floor now includes a much enlarged physiotherapy department and the medical records department, including chart storage.

The housekeeping job in a hospital like this is mammoth! So the housekeeper has been given a large office, centrally located on the main floor near the centre of the hospital. A stock of staple housekeeping supplies is kept in an adjoining room.

The Oshawa General Hospital, with its new facilities and its new good looks, now provides 237 medical and surgical beds, 65 obstetrical beds, 41 paediatric beds and 76 bassinets—a total of 419. But already planning for an additional 220 beds is in progress.

The new wing and renovations cost $3,000,000, financed by provincial and federal grants, grants from the County of Ontario, the town of Whitby, Townships of Whitby, East Whitby and Darlington, the Atkinson Foundation, proceeds of a $850,000 debenture issue of the city of Oshawa. A fund raising campaign produced $1,030,000 in donations from the citizens and industries of the area. The accumulated hospital funds provided the remaining $21,000.

The Oshawa General Hospital has had from its inception the confidence and support of many good friends. Never has a fund-raising campaign been called because of deficits, for the hospital has always been free of debt. It is proud of its record of nearly 50 years' service, and its pride is justified. We all believe that the hospital will continue to hold its head high as it offers comfort and help to the community. ■

Anti-snakebite Serum Available in Philadelphia

The Philadelphia Herpetological Society has announced that it has anti-snakebite serum for all North American poisonous snakes available for emergency use on a 24-hour basis. The service will be free to anybody in need of it. On hand are serums for bites from cobras, coral snakes as well as the North American poisonous snakes —rattlesnakes, copperheads, and water moccasins.

Persons wanting the serum should contact B. Rothman, 7036 Rising Sun Ave., Philadelphia, Pa.

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The Questioning Mind

(concluded from page 38)

colour and light we do know this, that they have an actual and physical effect. Variety of form and brilliancy of colour in the objects present to patients are actual means of recovery".

Visiting

The question of visiting brings up some interesting points. Many hospitals today have given this problem much thought and some of them have made changes to permit visiting anytime between 2 p.m. and 8 p.m. Despite their initial objections doctors and nurses find that this arrangement works quite well. But what about the patient? Do we ensure that visiting is well controlled? Visitors are extremely ingenious in slipping passes from one to another, even dropping them out of the ward window to other visitors. The ward then becomes full of them, sitting all over the patient and happily eating all his cake, fruit, and chocolates. We should be aware that although some visitors are of great benefit to the patient, the thoughtless ones can prove very exhausting.

Finally, there is the fact that many patients just want someone to talk to. In many instances, it is this need that lies behind the apparent sullenness of some patients and string of complaints that come from others. There should always be a system of notifying a particular chaplain when an admission takes place, for he is usually most expert at this difficult task of just listening. Sometimes the hospital auxiliary will help with this task; or a hospital may have a number of charitable persons who are pleased to visit patients who are normally without visitors. It is a problem that should not be overlooked.

The importance of the patient was mentioned earlier, and it follows from this that all who are connected, in any way, with hospitals are in a privileged position which should be appreciated. ■

"Rescue Breathing"

A new full colour film for teaching purposes is put out by the American Film Producers. "Rescue Breathing" presents practical, specific information vitally needed to save lives of victims of suffocation by electric shock, chest injuries, drowning, choking, drugs, and gas. It teaches the techniques of mouth-to-mouth or mouth-to-nose. "Everyone from eight years old up", a spokesman for the film states, "should see this film and learn how to administer rescue breathing". The film is officially approved and endorsed as a teaching film by the New York Society of Anesthesiologists and the American Society of Anesthesiologists. It may be obtained through the American Film Producers, 1600 Broadway, New York 19, N.Y.

New Graduate Course in Nutrition

A new post-graduate course in nutrition leading to a Diploma in Nutrition has been established in the School of Hygiene, University of Toronto this year. The new course will provide advanced training in nutrition, in public health administration, and in related subjects, to equip graduates in medicine to serve as nutrition specialists with health departments and international bodies such as the World Health Organization.

The course will correspond in academic standing to the Diploma in Public Health course, and to the Diploma in Bacteriology course. It will extend through one academic year.

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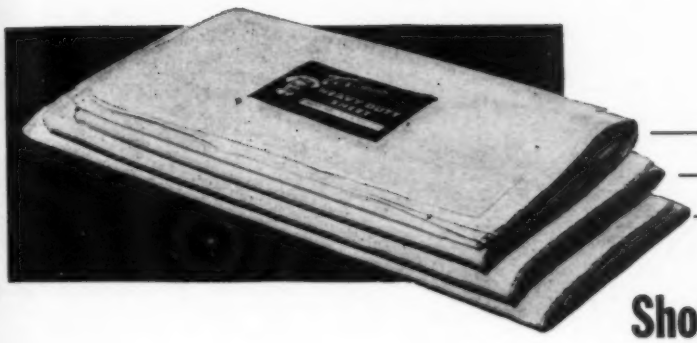

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Hospital Officials Meet Doctors' Nurses

Various attempts have been made by the Royal Jubilee Hospital, Victoria, B.C., to facilitate the admission of patients. One of these attempts was telephone admitting (see *Canadian Hospital*, February 1958). Another innovation may prove to be the most successful so far.

From the numerous phone calls made by admitting personnel to doctors' nurses for information on patients' diagnoses, et cetera, it became apparent that the nurses, although most co-operative, did not understand the problems involved. Generally speaking, they knew little about the hospital's policies on admission procedures or about the eligibility requirements of the hospital insurance service. It was obvious, therefore, that a meeting between hospital officials and doctors' nurses would be to everyone's advantage. A meeting was arranged and invitations were mailed to all doctors' nurse-receptionists in the Greater Victoria area. The doctors were told at a medical staff meeting that arrangements to meet with their nurse-receptionists were being made.

The nurses' desire to work with the hospital was apparent when 90 per cent of them came to the meeting. They were welcomed by the administrator and then the hospital's accountant explained the requirements of the admission-discharge record, placing particular emphasis on the application for B.C.H.I.S. benefits. The director of nurses spoke on the importance of co-operation between hospitals and doctors' nurses, especially when the number of beds was exceeded by the demand. The meeting was then turned over to the senior admitting officer who clarified all aspects of the hospital's admitting policies, such as the need for adequate confirmation of the patient's eligibility, the reasons for admission priorities, why tonsillectomies are booked four to six weeks in advance, and so on. She also asked their co-operation in advising elective patients to take proof of residence with them to hospital, preferably an employer's certificate or a written statement from a reliable reference.

This talk was followed by a question and answer period. Any doubts about the value of the meeting were immediately dispelled by the sincerity and enthusiasm with which problems were discussed. Coffee was served, and nurses and hospital personnel got to know each other better.

Officials of the Royal Jubilee Hospital were very satisfied with the improved relationships and better understanding of admitting procedures which resulted from this first meeting. They propose to hold a similar meeting at least once every year, depending upon such circumstances as policy and procedure changes.—*Dr. Murray Anderson in B.C.H.I.S. Bulletin.*

Special Chest Clinic for Victoria County

The Ontario Department of Health has opened a special chest clinic in Lindsay, Ont., to serve Victoria County. The clinic is for total control and the eventual eradication of tuberculosis in this part of the province. This ambitious project in tuberculosis control, if successful, will serve as an example to other parts of the country where infection rates are low.

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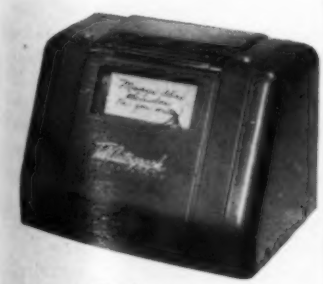

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For the Disabled

The Research and Statistics Division of the Department of National Health and Welfare, Ottawa, has published *Allowances for the Permanently and Totally Disabled, Medical Statistics.* This bulletin covers the period from April 1, 1956 to March 31, 1957, and has been prepared to inform officials administering the Disabilities Allowances Program on the extent and nature of disabilities suffered by applicants for the allowances. It also provides the material for an assessment of permanent and total disability in Canada.

Under the Disabled Persons Act, 1954 (which became effective January 1, 1955) the federal government provides financial aid to the provinces for the provision of allowances to persons age 18 or over who are totally and permanently disabled and whose income is below certain fixed limits. All provinces participate in the program. (Newfoundland, Ontario and Alberta had previously operated their own programs). Within the limits of the federal act, each province can fix the amount of the maximum allowance payable and the maximum income allowed. The federal government's contribution may not exceed 50 per cent of $55 a month or of the allowance paid, whichever is less. In all provinces and the territories the maximum allowance payable is $55, although some provinces pay supplements to this.

For an unmarried person, the total income allowed (including the allowance) may not exceed $960 a year; for a married couple the limit is $1,620 a year, except that if the spouse is blind, within the meaning of the Blind Persons Act, the total income of the couple may not be more than $1,980 a year. In each case, the exact allowance payable depends on the amount of other income and resources of the applicant and his spouse. To be eligible for an allowance, the applicant must not be receiving an allowance under the Blind Persons Act or the War Veterans Allowance Act, assistance under the Old Age Assistance Act, a pension under the Old Age Security Act, or mother's allowance under provincial legislation. He must have resided in Canada for at least ten years immediately preceding the commencement of the allowance, other than for certain temporary absences, or, if he has not resided in Canada for ten years, he must have been in Canada, prior to the ten years, for a total period equal to twice any absences in that period.

If the recipient neglects or refuses to take available training or rehabilitation, the provincial authority is required to suspend the allowance. The allowance does not go to a patient in a mental institution or sanatorium. A resident in a home for the aged, an infirmary, an institution for the care of incurables, a nursing home or a private, charitable or public institution, is eligible for the allowance only if most of the cost of his accommodation is being paid by himself or his family. (Effective July 1, 1957, the limitations on persons paying the whole or the greater part of the patient's accommodation was extended to permit "other relatives or any other private individual or individuals" to assist financially.) If he enters a public or private hospital, the allowance may be paid for no more than two months of hospitalization in a calendar year, except that it may continue to be paid for any period that he is in hospital for therapeutic treatment of his disability as approved by the provincial authority.

The province administers the program; the provincial plan for administration must be approved by, and cannot be changed except with the consent of the governor-in-council. Federal reimbursement is made through the Department of National Health and Welfare.

Coming Conventions

Sept. 22-23—Catholic Hospital Conference of Alberta, 16th annual meeting, Corona Hotel, Edmonton, Alta.

Sept. 28-Oct. 2—American College of Surgeons, 45th annual clinical congress, Convention Hall, Atlantic City, New Jersey.

Oct. 14-16—Saskatchewan Hospital Association, annual meeting and convention, Bessborough Hotel, Saskatoon, Sask.

Oct. 17—Catholic Hospital Conference of Saskatchewan, annual meeting, Bessborough Hotel, Saskatoon, Sask.

Oct. 18-19—Catholic Hospital Conference of British Columbia, annual convention, Vancouver, B.C.

Oct. 20-23—British Columbia Hospitals' Association, annual convention, Hotel Vancouver, Vancouver, B.C.

Oct. 21-23—Conference on Cerebral Palsy, sponsored by the Cerebral Palsy Association of Quebec, Inc., 10th anniversary conference, Montreal, Que.

Oct. 26-28—Ontario Hospital Association, annual convention, Royal York Hotel, Toronto, Ont.

Oct. 27-29—Associated Hospitals of Alberta, annual convention, Jubilee Auditorium, Edmonton, Alta.

Oct. 29-30—Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto, Ont.

Nov. 23-25—Hospital Finance Institute, sponsored by the Maritime Hospital Association, Moncton, N.B.

June 19-24, 1960—Canadian Nurses' Association, biennial meeting, Nova Scotian Hotel, Halifax, N.S.

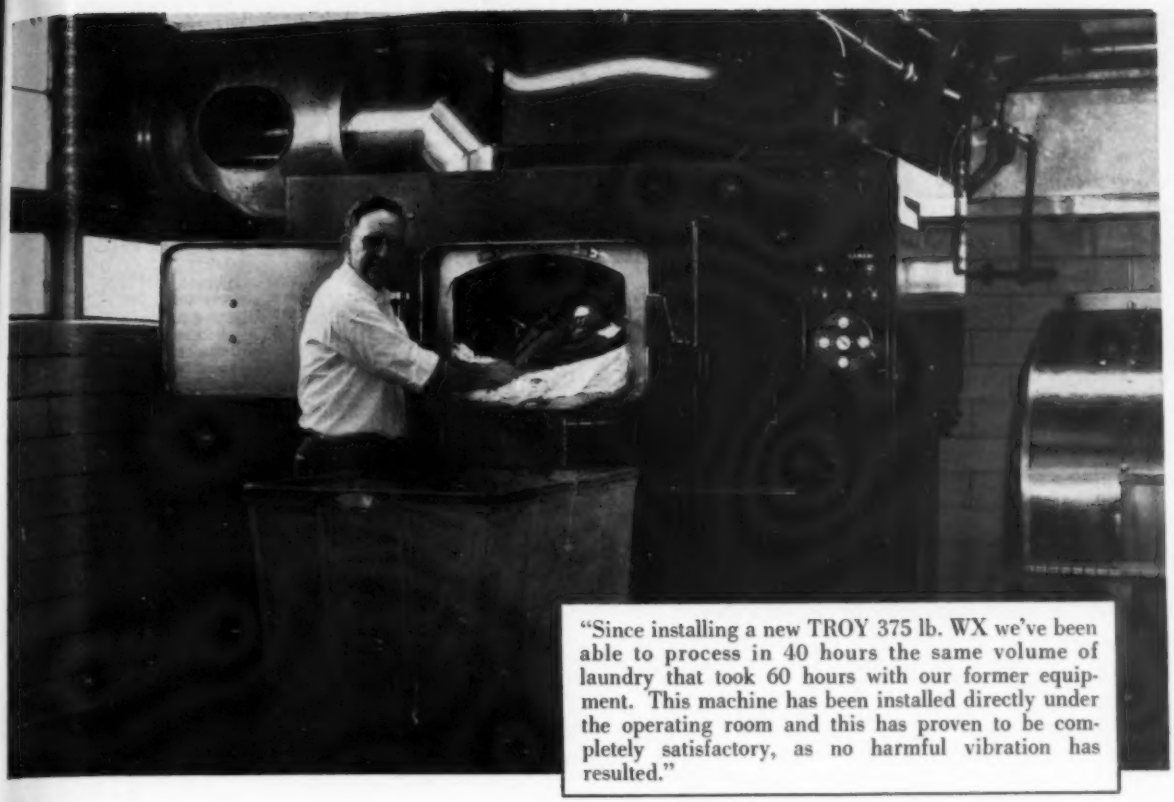
Increase in Construction Grants

An increase in construction grants to hospitals, from $5,000 to $6,000 per bed, was announced by Premier Leslie Frost at the opening of a new addition to Toronto General Hospital, Toronto, Ont. Cost of the increase to the province was about $1,500,000 this year.

Before the increase, bed grants were $4,000 per bed, but because certain grants were awarded for floor space not occupied by beds, the actual bed grant was $5,000. The new increase is expected to encourage hospital construction in Ontario.

A New Chapter

The United States entry in the Venice Film Festival this year was entitled "A New Chapter". It presented the story of one man's experience in readjusting to community life after he had been released from a mental institution. The film, designed for viewing by mental patients during rehabilitation, was conceived and sponsored by a well-known pharmaceutical firm.



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"Laundry Processing Time Cut 33⅓%"

. . . SAYS SIG. PAULSON, FAIRVIEW HOSPITAL, MINNEAPOLIS, MINN.

Check into these outstanding features of the new TROY WX WASHER-EXTRACTOR . . . features that have won the unqualified approval of the men who use them.

BIFURCATOR®—Exclusive! Fast, efficient cooling, conditioning and shakeout of linens; provides easier unloading. Linens ready for ironing upon removal from TROY WX WASHER-EXTRACTOR.

SPRAY RINSE FEATURES — Trunnion-type spray rinse provides faster, more efficient rinsing; shorter washing cycles; better quality. Less tensile strength loss.

FAST CYCLE FEATURES — Chart-type controls automatically put the TROY WX through all wash and extract cycles in less time than required for washing only on previous equipment. Flexibility of control provides repeat of cycles for extreme conditions, more reversals per minute — all controls conveniently located.

TROY BONUS QUALITY FEATURES — Complete safety features, ⅝" front shell plate, intermediate and high extraction speeds, stainless steel cylinder and shell sheets, heavy, durable shell door latch, perforated stainless steel partitions, stainless steel shell door, stainless steel lined front and rear shell plates, all V-belt drive — no chains or gears.

Troy® WX WASHER-EXTRACTOR
100 Lbs. • 200 Lbs. • 375 Lbs.

Write Dept. CH-959 for detailed bulletin

LAUNDRY MACHINERY (Canada) Ltd.
132 McCaul Street
Toronto, Ont.

They Smile and Smile . . .

Maggie Grant,
Toronto, Ont

THE advertisements in most magazines are inclined to make me twitch. This is because everyone is so persistently smiley. Mother, father, and any number of pink-and-white kiddies smile and smile and smile as they enjoy togetherness in the newest and finniest automobile, or whomp up hamburgers on a Genuine Prefabricated Olde Tyme Bar-BQ. They smile and smile and smile because Mom has made jelly for dessert, because Dad has bought some rubber stair treads, and because everyone is wearing the same brand of running shoe.

While I can find little pleasure in cleaning toilets, advertisement housewives seem to adore the task, beaming ecstatically as they employ some Amazing New Discovery, and down at the office their husbands are dictating frightfully amusing stories into their dictaphones, to judge by their expressions.

At the risk of being dubbed an old cross-patch, I must confess all this smiling makes me just a teeny bit sick at my stomach. It was with a feeling of release, then, that I perused a back copy of *Canadian Hospital*, a magazine devoted to the hospital field, which strayed into these layman hands by chance. Advertising in this publication is earnest. It runs truer to life, I feel. Many ads stress the product itself, with good clear pictures of a rubber glove, or a resectoscope (with two-finger grip handle) or a non-ravelling elastic bandage.

However a touch of snobbery creeps in. In one case, under a full-page picture of a cast (unoccupied) we read:

"The bank manager of a small town fell and suffered a Colles fracture. This cast was removed in perfect condition after three weeks hard wear!"

To me a Colles fracture is a Colles fracture, whether it belongs to a bank manager or not, so why stress the point?

While human models are used in some cases, they behave extraordinarily like ordinary people—no beaming from hospital beds

(continued on page 104)

Maggie Grant is a columnist with Toronto's "Globe and Mail". Reprinted with the permission of the author.

They Smile and Smile
(concluded from page 102)

and saying, "I do so enjoy the All Clear Plastic Oxygen Mask" and "Having a baby is nothing when your doctor uses the 500N delivery table—it provides maximum comfort and freedom for the surgeon!" No, they just lie there looking rather dull and sleepy. The patients, that is.

With the staff it is slightly different. Of course, a medico in complete operating room regalia (complete sterility both back and front) might be hiding any expression under that mask, but in a plug for a brand of x-ray film, a young doctor permits himself a very slight smile. However, toward this I can feel indulgent. After all, he has before him a beautiful picture of someone's intestines, and who wouldn't show pleasure at that?

But I cannot condone the only genuine tooth-paste grin in the entire journal. This is displayed by an extremely pretty nurse who apparently has just exclaimed: "Enemol makes giving enemas an easy chore."

All very well, Miss, but wipe that smile off your face when you get around to my bed. ■

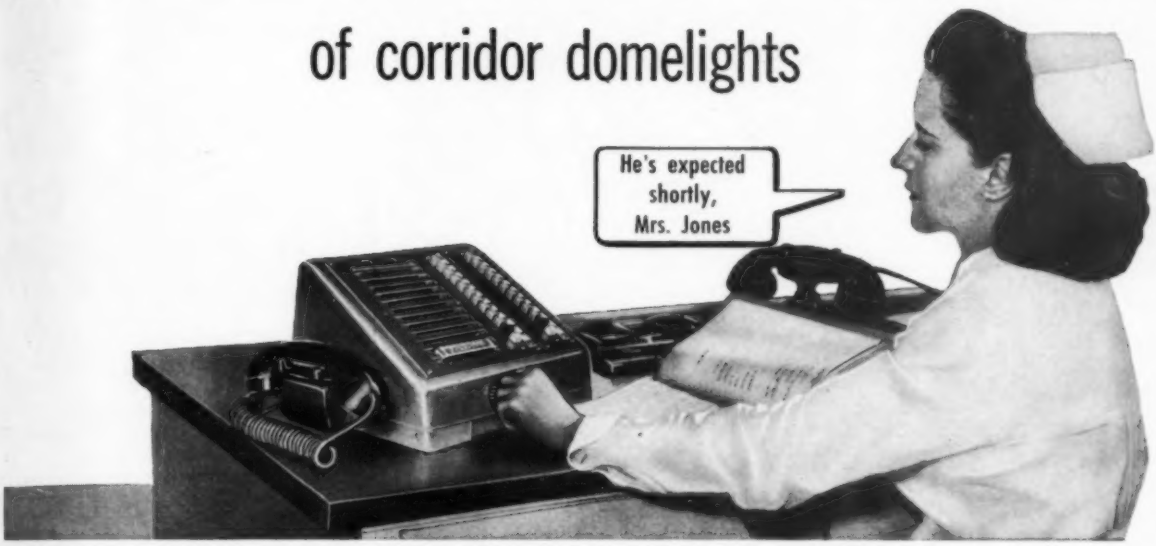
Mediscope '59

The Ontario Medical Association will hold a medical exposition in Toronto's Queen Elizabeth Building, Exhibition Park, October 12 to 17 this year. Called Mediscope '59, the exposition will let the public see exhibits demonstrating the history, present status and future of medicine. Visitors will look at exhibits ranging from the development of a baby to the illnesses of old age.

The O.M.A. hopes to improve health standards by informing the public about medicine. It also hopes to reduce common fears of doctors, hospitals and medical treatment. Doctors and medical technicians will be at the exhibition from 10 a.m. to 10 p.m., to demonstrate medical techniques and to answer questions.

One of the exhibits will be a reconstruction of a full-size hospital laboratory set up to show how the pathology department operates. Another will show how a baby with an Rh factor anomaly has all its blood replaced by transfusions. And still another will feature the stethoscope; 15-20 people will be able to apply earpieces and listen to a beating heart.

Add **AUDIO** easily to your present **VISUAL** nurse call system of corridor domelights



Executone's DEPENDABLE Audio-Visual Nurse Call System Cuts Foot Travel in Half!

Easily and quickly added to your present visual domelight system, Executone frequently uses *existing* conduits or raceways—providing you with a *modern* Audio-Visual Nurse Call System! All accomplished with no interruption of service during installation!

Many hospitals—old and new—are discovering the economy and efficiency of Executone's Audio-Visual system. More patients are handled with *less effort, in less time!* One hospital reports that Executone has reduced operating costs 8% per bed. *It is an invaluable aid in relieving the nurse shortage.*

By pressing a bedside button, the patient activates signals at three locations—chime and light on nurse's control station, corridor domelight, buzzer and light on duty stations. The nurse presses key to reply... Executone's Call System may be installed complete, added to existing domelight systems, or installed without domelights.

Just off the press!

"Better Patient Care"

How Executone communications help hospitals improve patient care and make maximum use of nursing time and skills. Includes a summary of time and motion studies of Executone Audio-Visual Nurse Call Systems made by the Surgeon Generals' offices of the Army and Air Force. Also described and illustrated are Doctors' Paging Systems, Bedside Radio-Sound Systems, Departmental Administrative Systems. Send in the coupon below for your complimentary copy.

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Without obligation, please send me a complimentary copy of "Better Patient Care."

Name ..... Title .....

Hospital .....

Address .....

City ..... Prov. .....

Twenty Years Ago

From the Canadian Hospital, September 1939.

In connection with the tercentenary of the Hôtel Dieu de Québec, one of the unique ceremonies was the visit of the thirty cloistered Sisters of the Order of St. Augustine, attached to the Hôtel Dieu, to the nearby monastery of the Ursuline Sisters, both of these orders being so intimately connected with the early life of Quebec three hundred years ago. Thirty Ursuline Sisters were also given the privilege of leaving the cloister to accompany the Augustines back to the Hôtel Dieu for a short visit there. This was the first time in thirty one years that any of the nuns had left the stone walls of the hospital cloister.

* * *

Those interested in hospital care insurance will follow the low price plan being developed in Greenville, South Carolina. The plan contemplates widespread public ward service for as many as possible of the 140,000 people in this community. About half of the people live in rural areas and are largely coloured cotton-growing tenant farmers. It is understood that the premium will be ten cents per week for individuals and twenty cents weekly for families. Ward services with certain auxiliary services are being supplied at $3.00 a day. This is a very low premium, especially as it provides for individual and family enrollment, but it is probably based upon the assumption that a large percentage of these patients would be non-paying patients anyway. One real difficulty to be encountered by this plan will be the problem of collections, which is always a bugbear with individual or with rural enrollment. It will focus attention however upon the necessity of developing some sort of plan to meet the needs of those in the lower income brackets.

* * *

With war clouds settling over Europe and with the probability that Canada may shortly be participating, would we not be wise to take thought and view this situation from the hospital outlook?

Those who remember the last war will have reason to consider the effect it had on our hospitals—staffs were depleted, doctors, nurses, interns and orderlies responding to the call in large numbers. Emergency arrangements were set up to care for the returned soldiers. Those same problems are liable to face our hospitals in the near future, if dictators are permitted to ride rough shod over the peace-loving nations of Europe. Are we prepared?

Administration

(concluded from page 52)

new leaders in hospital administration will be certain proof of his administrative skills. If the administrator understands that he must share his responsibilities with his co-workers, then only can he do justice to the manifold duties of his profession.

As he communicates with the members of the hospital staff, he will inspire them. Through department meetings, et cetera, the administrator will instruct his helpers in the importance of their functions. He will inform them of policies formulated for their benefit and for the benefit of the patient. He will help them solve their problems with sympathy and understanding. He will talk to those who want his advice. And he will be a good administrator. ■

Let Your Greetings Help a Child

UNICEF greeting cards this year are coming out in a variety of attractive designs. Six different artists of international repute have contributed their talents to help a child. A brochure picturing the selection of designs and including an order form will probably be coming your way. Be sure to take advantage of this way of helping feed and make healthy some child who needs such assistance. The proceeds from every box of cards (10 cards cost only $1.00) help UNICEF buy many of the things vital to underdeveloped countries striving to alleviate disease among children. Think of it! One box of cards can provide 45 children with a large daily glass of milk for a week. Five boxes supply enough vaccine to protect 300 children against tuberculosis. From ten boxes come enough medicine to cure six victims of leprosy.

Coming as either greeting cards (with "season's greetings" in five different languages printed on them) or as note cards, the UNICEF greetings can be imprinted with your name and/or address for an additional 40 cents per box— minimum order 10 boxes. Look for your order form in the mail. Address inquiries to: U.N.A. Committee for UNICEF, 280 Bloor St. West, Toronto 5, Ontario.

Physicians Co-operate in New Assault on Cancer

Information to help communities take advantage of cyto-diagnosis as an aid to early cancer detection has been furnished by the College of American Pathologists. In booklet form, the information is designed to help physicians use the latest techniques for the collection of cellular material. Although the procedure is described as useful chiefly in connection with detection of cervical cancer, methods for sampling cells from other body organs such as lungs and stomach, are also presented. Additional copies are available to doctors from the College of American Pathologists, Prudential Plaza, Chicago 1, Illinois.

Glaucoma Clinic

A giant free Glaucoma Clinic, sponsored by the Lions Club of Winnipeg in co-operation with the Winnipeg Medical Society, was held recently in that city. Anyone over the age of 40 was entitled to come for a free glaucoma test.— *Canadian Journal of Public Health*

8 second magic in I.V. set-ups

remove metal seal and disc

plug set into center of stopper by a quick thrust

quickly invert bottle to automatically establish fluid level in drip chamber; clear tubing of air and infuse

CUTTER

ANNOUNCING... THE FIRST MAJOR ADVANCE IN SOLUTION SYSTEMS SINCE DISPOSABLE SETS

THE CUTTER SAFTISYSTEM "28"™*

the most advanced and progressive complete I. V. system ever offered to hospitals

can be set up in just eight seconds... provides a single point of entry for the set... eliminates the air tube... a single thrust plugs in the set... a single movement inverts the flask—simultaneously providing a visual check for vacuum and an automatic establishment of drip chamber level... allows only filtered air to contact solution... makes it easy to add medication at any time... saves time, especially on tandem hookups... decreases the danger of air embolism during blood infusion... compatible with all closed systems of I. V. administration.

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STANDARD SURGICAL SUPPLY, LTD., 110 11th Ave., S.E., Calgary, Alberta
STANDARD SURGICAL SUPPLY, LTD., 167 West 2nd Ave., Vancouver, B.C.

Quantity and Quality
(continued from page 39)

board statistical analyses of costs of drugs and medical supplies do *not* show the acceptable variation in medical practice from area to area. They do *not* show the pressures under which hospitals are operating in areas where there is a shortage of hospital beds.

Those involved in government planning of hospital insurance should therefore consider some method of more closely tying the statistical with the personal individual approach. The first essential is that there should be an accurate assessment of the bed needs of each area. This assessment should not be confined to stating merely that a certain number of beds is needed. In fact, the decision should be based on a total plan of providing all varieties of hospital beds to cover the requirements of the area. A frequent error to which the pure statistician is prone is to use past and existing use as the yardstick for future construction without reference to any other sociological considerations than a presumable increase in population. Sociological factors, such as housing and the general standard of nutrition of the population in the area, should be considered. For instance, hospital requirements in the Indian Reserves or in areas with high Métis population, where the nutritional standard of the population is in doubt, are at least 50 per cent higher than in those where a higher standard of living exists. The hospitalization experience in Saskatchewan has been shown to vary considerably from around 185 discharges per 1,000 population in the cities to highs of 230 and above in village communities. Many factors undoubtedly influence this.

A more accurate approach might be to analyze the age groups in areas served; and apply to the number of the different age groups, in accordance with the age sex distribution, a statistical average number of beds. This would be preferable to the blanket application of a certain number of beds per 1,000 population so commonly practised.

The problem of ensuring the highest level of professional use of hospital beds is one which is only now interesting the medical profession. They now realize that their failure to regulate the use may result in increasing state control. The colleges could well consider assuming a very much higher responsibility over the quality of medical care in hospital especially in the smaller units with limited staffs. This obviously would involve the colleges in some form of centralized medical audit.

In addition, insufficient information is available on acceptable standards of nursing service. A country-wide recommendation of so many hours of nursing service is not really practical or useful. Recommendations should be produced by experts, indicating the allocation of nursing service in detail for the different areas of the hospital, such as the recovery room, operating rooms, acute surgical wards, and medical cases. These recommendations should bear a practical relationship to the local supply of hospital beds. To apply the same standards of over-all nursing care to an acute general hospital in a metropolitan area with four beds per 1,000 population and a 25-bed hospital in a rural community with eight beds per 1,000 is manifestly impractical. Average length of stay should be a vital component of any such

(concluded on page 112)

Quantity and Quality

(concluded from page 110)

approach. The establishment of such standards, provided they are regarded in a flexible fashion, would be of immense assistance not only to administrators of hospitals, but also to government officials responsible for decisions on hospital budgets.

It is certainly true that length of stay is a factor, since the short length of stay case usually requires very much the same total servicing by the hospital facilities as cases requiring longer admissions. A hospital with a fair number of lengthy stay cases can, in many instances, balance its budget better through the leavening factor of the lengthy stay case. One presumes, of course, that the lengthy stay case is the type of case which ordinarily should be cared for in a chronic facility. Many long-stay cases in our acute hospitals actually require acute hospital service and these are high-expense type of cases, requiring most expensive drugs and transfusions for long periods of time. These are, however, the exception rather than the rule.

There is no doubt that there is room for much study of the actual costs of treatment of varying types of cases. A case cost analysis, where it is available, could reveal very clearly whether or not the admission was diagnostic or was justified on medical or surgical grounds. Such a case cost analysis would require a considerable amplification of our present record systems and would require a certain amount of skill in setting up its bases. Nonetheless, if, and it seems certain, we are to be managed by statistical methods, those statistical methods must be expanded, so that they take into account most of the human factors which concern us in operating hospitals. There is nothing more difficult to evaluate than those human factors. Such evaluations have been tried in the various mechanical medical audit systems. Nonetheless, to attempt to regulate hospital plan payments on a basis which ignores the human factors is to ask for a replacement of quality by quantity and, in effect, to stultify all attempts of hospitals to grow, develop and to improve the general field of their service to their communities. ■

He that wrestles with us strengthens our nerves and sharpens our skill. Our antagonist is our helper. —*Edmund Burke.*

On Your Shoulders

(concluded from page 70)

a highly organized unit, operating very efficiently, and at the same time you may not be aware of some of the inner workings. If we are going to retain the type of hospital services and accommodation that we have been used to in the past, and if we are going to keep our hospitals as local units without having them under the complete management of the province, then we as trustees must carry out our responsibilities as we have in the past—by watching carefully the cost factors in the operation of our hospitals.

There is no better way to control the cost factors in your hospital than to investigate every possibility of improving and developing the personnel policies and management programs in your institution. I submit also that in some cases a personnel officer is required to see that there is uniformity in various policies throughout the organization. I believe, for example, that a director of nurses can do a much better job if she is assisted in selecting and counselling her staff by a personnel director.

With national hospital insurance, we are now confronted with an entirely new situation, especially in considering the personnel who are going to do the work that makes the service possible throughout the province. It requires a new approach in selling to these employees the ideas that are necessary for their doing a better job. It is also necessary for us to provide equipment of all kinds that will reduce the amount of labour to the bare minimum. We must keep in mind too that to retain our autonomy we must make a contribution as a unit to the community.

I am satisfied that we have, in our provincial hospital association, people who are capable of developing this kind of program and, together, they may assist the hospital services commission of Ontario in reducing the cost of maintaining our hospitals and in still keeping the standard of service that has been established so well by those who have gone before. ■

On Loving

So long as we love, we serve; so long as we are loved by others, I would almost say that we are indispensable; and no man is useless when he has a friend.—*Selected.*

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 57 Bloor Street West, Toronto 5, Ontario. Rates for classified advertisements are as follows:

$3.75 per column inch or fraction thereof, minimum charge $3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no additional charge. ¼ page display advertisement—$25.00. Advertisements must be received by the first of the month to appear in that month's issue.

Druggist

desires good position and benefits. Apply: c/o Neil McKenzie, 40 Queen Street, Room 319, Brantford, Ontario.

Nursing Superintendent

required for modern, accredited 60 bed hospital. Living accommodation available. Apply stating qualifications and salary expected to: Superintendent, Barrie Memorial Hospital, Ormstown, Que.

Assistant Radiologist

Certified in Diagnostic and Therapeutic Radiology. Active 350 — Chronic 110. Apply, W. Hatch, Administrator, Kitchener-Waterloo Hospital, Kitchener, Ontario.

MEDICAL DIRECTOR

Applications are invited for position of Medical Director in a 560-bed general hospital in Southern Ontario (Expansion program).

State qualification, experience, age, etc. All applications will be treated confidentially. Apply box 8025, Canadian Hospital, 57 Bloor St. W., Toronto, Ont.

CHILDREN'S HOSPITAL OF WINNIPEG

invites application for position of

Director of Nursing

New 250 bed Paediatric Hospital and Nurses' Residence, with own School of Nursing and affiliate Programme. Assistants in both Nursing Service and Nursing Education.

Salary—according to qualifications and experience.

For further information apply to, Superintendent,

CHILDREN'S HOSPITAL OF WINNIPEG,
Winnipeg 3, Manitoba

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes inquiries from Hospital Trustee and Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

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We pride ourselves on careful screening of all clients and thorough investigation of openings. Our aim: to match the applicant and the specific position.

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CHIEF DIETITIAN REQUIRED

A splendid opportunity for a dietitian with organizing ability required by the Beck Memorial Sanatorium to start immediately. Five day, forty hour week, generous sick leave, vacation, pension, life insurance plans in effect. Cottage residence (unfurnished) or furnished suite available at nominal cost. Salary commensurate with experience and qualifications. Apply, giving age, training, experience and references to the

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All replies treated confidentially.

REQUIRED
BUSINESS ADMINISTRATOR
(a new position)
for
The Saskatchewan Hospital,
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a 1,700 bed mental hospital with a staff of over 600.

SALARY—$736-$895 monthly

DUTIES—The Business Administrator is responsible to the Medical Superintendent for:

1. **Budgeting and Accounting**
   a. Supervising the preparation of the annual financial estimates so that they will reflect the long term and short term programs of the hospital.
   b. Instructing division heads in the techniques of estimating their requirements in financial terms and instructing them on effective means of control.
   c. Exercising general supervision over expenditures and reporting regularly to the superintendent on the financial situation of the hospital.
2. **Line Functions**
   To supervise those division heads of the hospital who are concerned with accounting, maintenance, power, farming, gardening, automotive services and institutional services (laundry, cleaning, etc.)
3. **Consultant**
   To advise the superintendent on matters such as organizational structure, the depreciation of the physical plant, utilization of space and standards of service.

QUALIFICATIONS REQUIRED:
Graduation from a two year university course in hospital administration, responsible administrative experience, and preferably experience in mental hospital work.

HOW TO APPLY: Write to the Personnel Officer, Department of Public Health, Health and Welfare Building, Albert Street, Regina, Sask.

Employment Opportunity With The Hospital Services Commission of New Brunswick

HOSPITAL ADMINISTRATIVE CONSULTANT

Duties: Responsible for inspection of services provided in each Hospital and submitting reports in respect to staffing, salaries paid, facilities, equipment available, arrangement of and supervision of consulting and training programs, institutes and courses to improve work methods and standards of service, advice to Hospitals and the Hospital Services Commission in respect of new buildings, extensions or renovations required.

Applicant should preferably have a degree in Hospital Administration or a sound background in the administration of a Hospital.
Salary: $5700-$7200, with annual increments of $300.

Apply to: **Hospital Services Commission**
P.O. Drawer 1297 Fredericton, N.B. Telephone Granite 5-9445

Psychiatry
(concluded from page 60)

vice into the over-all organization completely, to give it vitality, and to assure the intelligent co-operation of the medical practitioner and the hospital personnel, a planned educational program is essential. So far, attempts to break down the wall of ignorance and prejudice and to engage public interest in mental health have met with mixed success. Because the general hospital is part of the community which people know and with which they identify themselves, it is ideally situated as a post through which information can be disseminated and the community educated in mental health. This should result in a more favourable climate in which: (a) people with psychiatric problems will seek help early and will be able to count on the full sympathy and support of the community; (b) healthy attitudes will be promoted in the community and mental illness prevented; (c) a larger number of potential health workers will come to the psychiatric field; and (d) mental health will receive just economic consideration.

Medium-sized hospitals should provide a complete in-patient and out-patient psychiatric service. Although the service in a small hospital is of necessity limited, it can be most effective and important to the community. A psychiatric out-patient clinic is the usual solution. A visiting psychiatrist can come there to diagnose and treat patients referred to him and do preliminary investigations on those who must be sent to a larger centre. The visiting social worker can make case studies, help with family emergencies and assist with follow-ups. The idea that the cost of treatment in a general hospital is excessive is erroneous—experience shows that it compares favourably with that of other clinical services. The general hospital cannot satisfy the needs of the community nor provide truly comprehensiye care while it ignores the problem of the mentally sick.

It is time that the policy of isolating the mental patient from the physically ill be stopped. In any future health planning, thorough consideration should be given to the important contribution which the general hospital can make toward solving the mental health problem in our country. The merits of a psychiatric department in the general hospital may be summarized as follows:

(a) It provides a favourable psycho-therapeutic *milieu* which facilitates early diagnosis and effective treatment without interrupting family-doctor-patient relations.

(b) By treating the patient within the hospital, which the community considers its usual place of healing, it removes the barriers of prejudice and distance which isolate the mental hospital from the community.

(c) It integrates psychiatric services within existing health facilities, thereby improving health services to the community and raising the general standard of patient care in the hospital.

(d) Through centralization, it makes possible effective economies of facilities and of scarce personnel.

(e) It is an ideal centre for a preventive program and for staff and community education.

(f) It encourages health workers to specialize in the psychiatric field.

The federal Hospital Insurance and Diagnostic Services Act excludes mental hospitals from its provisions, but it does include psychiatric services in a general hospital — either on an in-patient or an out-patient basis, subject only to federal-provincial agreements. Hospitals should seize the opportunity which the federal-provincial provision grants and the hospital insurance program offers, to try to help solve a health problem which is increasing in its magnitude. ■

Group of Ten

Only three years ago a small group of women in Montreal took up painting as a hobby. Today through the sale of their pictures they have made their hobby pay off — and pay off in more than just the financial sense. This group, calling themselves the Clavis Studio, have contributed their sales —amounting to nearly $1,000 — to the rehabilitation and occupational therapy departments of the Verdun Mental Hospital.

The ten women have made the hospital their charity project and aid it by holding exhibitions and sales which have been most successful. Only last April they exhibited over 100 paintings—not only ones they had produced but works of Hungarian artist Rudolph Cserjes and photography prints of Dr. I. F. McHaffie as well.

Personality: The name we give to our own little collection of funny habits.—*English Digest.*

News Released by Hospital Supply Houses

By C.A.E.

New Hi-Lo Bed Featured by Royal Metal

One of the units in the new and complete line of furniture for hospital patients' rooms and wards, recently introduced by Royal Metal Manufacturing Company Limited, is their Hi-Lo Bed. A new spring-assisted lift makes it possible to raise or lower the entire bed with just 26 turns, put it into Trendelenburg position in 10 seconds, or complete the entire cycle to the Fowler position in just 25 seconds.

Royal hospital furniture is sold exclusively by The Robert Simpson Company Limited Contract Division (Hospital Section).

British Oxygen Emergency Resuscitator

Known as the AMBU, this resuscitator can provide unlimited respiration with atmospheric air (more than 50 litres/minute if required) independently of fixed installations and services. In emergencies atmospheric air is adequate and provides for thorough oxygenation of the blood. For special cases the unit can be used in conjunction with an oxygen supply.

The bag is self-inflating, owing to its special lining of foam rubber, and is so sensitive that the operator can easily detect obstruction in the airways of the patient.

During artificial respiration the bag is rhythmically compressed forcing air through the mask-connection into the patient's lungs. A non-rebreathing valve ensures that the air forced to the patient passes to atmosphere upon exhalation. Atmospheric air is sucked through an inlet valve into the bag when the operator releases pressure on it. A foot operated suction unit is also available.

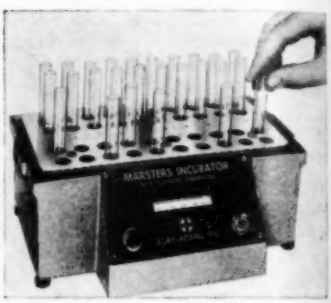
The compactness and simple operation of the AMBU resuscitator makes it an indispensable part of the emergency equipment of hospitals, doctors, dentists, ambulance services, fire and police departments and industry first aid rooms.

Complete information available from The British Oxygen Canada Limited, Horner Avenue Toronto 14.

Clay-Adams Test Tube Incubator

A new test tube incubator for use in blood banks and haematology laboratories affords the conveniences of waterless operation in a tabletop unit that is light and easily movable.

Named the Marsters Test Tube Incubator after Roger W. Marsters, Ph.D., who developed the highly efficient and compact instrument, it provides accurate temperature control at 37°C, plus or minus one-half of one degree, for as many as 40 test tubes at a time. Tube sizes 10mm to 13mm are accommodated, including



Kahn, Sero and blood collecting tubes. Up to 2 ml. fluid may be incubated in each tube.

Waterless feature of the unit eliminates the water bath problems of cleaning and adjustment —there is no evaporation, stagnation or contamination of water. Thus, maintenance and muss are reduced to a minimum. Compact design (9½" x 7" x 3" high) and light weight (9 lb.) allow for operation on a rotator or shaker to speed reactions by agitation during incubation.

The instrument reaches the 37°C operating temperature from the "cold" state in 30 minutes, and may be left on indefinitely, ready for immediate use. Specimens reach 37°C within 4 to 5 minutes. Temperature of the incubator is shown on an illuminated, removable thermometer mounted in the front panel. A neon pilot light indicates when current is flowing to heating element.

The Marsters Incubator is of

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Borden Guide to better food purchasing

BORDEN'S TRUMILK. Whole milk, cream and all, in handy, powdered form. Add 7 parts water to 1 part Trumilk by weight. No refrigeration needed.

BORDEN'S BREADLAC. Spray-process skim milk powder specifically designed for baking. Actually increases yield and quality of baked goods at no extra cost!

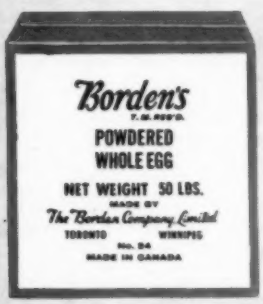
BORDEN'S MILKSTOCK. High grade, all-purpose skim milk powder. Exclusive spray process assures quality and uniformity. Always available—no refrigeration needed.

Check these Borden advantages:

More Economical!
Quality guaranteed!
Continuous supply assured!
Less storage space required!
No refrigeration needed!

BORDEN'S GOLDEN GLO DRIED WHOLE EGGS. No waste with breakage or spoilage. 1 lb. equals 24 fresh farm eggs with 33% sweetener already added. No refrigeration needed.

BORDEN'S POWDERED LEMON JUICE. 1 lb. equal to the juice of 48 freshly squeezed lemons. Labour-saving and economical for pies, tarts, fillings.



BORDEN'S DRIED WHOLE EGGS. For any recipe calling for eggs. Saves storage space, assures year-round supply. 1 lb. equals 36 fresh eggs.

For quantities and servicing to fit YOUR EXACT NEEDS ... call your Borden Man!

If it's Borden's it's got to be good!

THE BORDEN COMPANY LIMITED,

Dry Milk Department, Spadina Crescent, Toronto 4, Ontario • 6290 Perinault Street, Montreal 9, Quebec

DISTRIBUTORS

The Borden Company Limited, P.O. Box 2155, St. John's, Nfld.

Kennedy Agencies, 13 North Wharf, Saint John, N.B.

McKenzie Stephenson Ltd., 345 Higgins Ave., Winnipeg, Manitoba.

Kirkland & Rose, (I & A) Ltd., 130 Water Street, Vancouver, B.C.

Across the Desk
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aluminum block construction, finished in gray hammertone enamel, and with a chromed steel top plate. Sealed heating element is controlled by an extremely sensitive mercury thermostat. Operates on 110-115 volts, 50-60 cycles AC. It is available through surgical and scientific dealers. Additional information may be obtained by writing to the manufacturer, Clay-Adams, Inc., 141 East 25th Street, New York 10, New York.

Arborite Plastic Laminates in 79 Colours

Inspired by the latest trends in institutional home and industrial decorations, Arborite is revamping its line of plastic laminates which are now being introduced in 79 gay colours and patterns. Offering more scope for decorators, the wide "Colour-Magic" range includes elegant new marbles, new holidays, and new wood-grains, as well as Arborite's latest patterns of plazamosaics, and golden glitters.

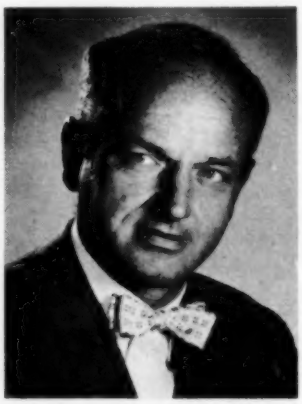
The new streamlined selection offers a large choice for the most demanding job, and at the same time, it keeps necessary stock requirements to a minimum.

Twin-Trim 6 (1/16") is available in a wide selection of "Colour-Magic" colours and patterns.

To introduce the "Colour-Magic" line, Arborite invites consumers to write in for samples of the new patterns and colours which will be presented in a handy, pocket-sized chip box. Attractive display boards based on the "Colour-Magic" theme are being made available to dealers.

Baxter Research and Development Appointment

Dr. Leonard G. Ginger has been named vice-president of research and development for Baxter Laboratories, Inc. Starting as assistant scientific director at Baxter 10 years ago, Dr. Ginger has since successively held the positions of director of organic research; director of chemical research; and director of research and development, his most recent assignment.



Dr. L. G. Ginger

Dr. Ginger has a Ph.D. degree from Yale University, a M.S. degree from the University of Chicago, and received his B.S. degree from Northwestern University.

Baxter, with its Hyland and Travenol divisions, is a leading manufacturer of pharmaceuticals.

Ingram & Bell Limited Acquired By International Bronze

International Bronze Powders Limited, a public company controlled in Canada, whose stock is listed on the Toronto and Montreal Exchanges, has acquired from certain principal shareholders of Ingram & Bell Limited, 51 per cent of the common stock of that company.

International has made an offer to all other shareholders of Ingram & Bell registered in Canada to acquire their shares on the same basis, which is $13.50 per common share and $12.50 per preference share.

The policies of Ingram & Bell Limited, and its operating personnel, remain unchanged. Established for 54 years, the company which is Canada's largest in the field of physicians and hospital supplies, has branches in Montreal, Winnipeg, Calgary and Vancouver, with its head office and factory in Toronto.

With C. C. White remaining as president and W. F. Jones as vice-president, it is anticipated that Ingram & Bell will prove an important part of International's entry into the Canadian health supplies field. In this connection it will be remembered that International last year acquired Lymans Limited, a wholesale drug business established in Montreal in 1800.

New Modular Line By Office Specialty

The Office Specialty Manufacturing Company Limited is marketing a new wood modular line called "Modall". The deep walnut finish, blending arborite top, distinctive metal leg assemblies and walnut-cane panel are some of the elements contributing to the line's well designed handsome appearance.

Pedestals are available in either three box drawers or box and vertical drawer combination. Through the use of "Modall's" shelf filing and bookcase components and similar units, a truly functional workplace can be set up for every particular office need and position.

New Micro-Filter Added to Air-Shields Line

An exclusive new Micro-Filter has been added as standard equipment to Dia-Pump compressor-aspirators, of the Isolette® infant incubator. In addition, the company now offers three economical models, the Dia-Pump compressor only for controlled positive pressure to 30 p.s.i.; the Dia-Pump aspirator only for regulated

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suction provides up to 22" Hg of vacuum; and the dual purpose Dia-Pump compressor-aspirator, which combines pressure and suction in one compact portable unit.

The Micro-Filter is designed to protect patients and operators of the Dia-Pump from dangerous cross infection. Four layers of glass fiber filter, permanently housed in a unique disposable plastic container, remove all contaminants down to 0.5 micron in size from room air to insure a safe source of pathogen-filtered compressed air. When the Dia-Pump is used for suction, bacteria from aspirated material are removed by the Micro-Filter before air is discharged into the room, thus reducing the hazard of cross-infection to patients and operator.

All Dia-Pump models are diaphragm-type pumps designed for continuous heavy duty operation, and mounted on a plastic-coated steel frame with rubber feet to suppress noise and vibration. They are powered by a 1/6-HP motor which operates on 115-volt, 60-cycle, A.C. and are equipped with three-wire safety cord and adapter plug for standard outlets. Special models are available for use with other currents.

Information regarding the Micro-Filter may be obtained from Air-Shields Canada Limited, 8 Ripley Avenue, Toronto 3.

New Floor Seal Introduced by Dustbane

A new terrazzo, ceramic and concrete floor seal, D. B. Tero Seal, has been introduced by Dustbane Associated Companies.

D. B. Tero Seal provides a tough, homogenous skin over the pores of the floor, preventing stains from dirt, oil, gasoline and alkalis. It is crystal clear and non-oxidizing, preserving the original appearance while adding a glossy sheen to the floor.

This new product adds an anti-slip quality to the floor so that non-permanent resin or wax finishes may be applied, increasing the protection and adding to the beauty of the floor. It can be patched without showing overlap and may be completely removed safely and easily with readily available solvents.

D. B. Tero Seal will not thicken or form a skin in a partly used container. It is easy to apply and dries in 20 minutes.

Canadian Sanitation Standards Association Meeting

The newly formed Canadian Sanitation Standards Association held their second quarterly meeting recently in Toronto, as 37 members and guests enjoyed dinner and discussed the future of the new association and the sanitation industry in Canada.

Stan McKenzie, Thomas L. Gibson Company, C.S.S.A. president, opened the meeting and invited applications for membership from established ethical sanitation manufacturers, distributors, jobbers, cleaning maintenance contractors and suppliers to the industry. "There is educational work to be done," said president McKenzie. "We are organizing in Ontario and eventually in each province and every effort will be put forth to improve the standards of our industry."

Gordon Hay, of Gordon A. MacEachern Limited, acted as moderator for a panel, consisting of C. E. (Chic) Evans, assistant manager, The Granite Club, representing consumers; A. Bartholomew, Behr-Manning (Canada) Limited, and Chas. Douglas, E. B. Eddy Company Limited, representing associate members; C. S. Burton, Burton's Sanitation Limited, and H. L. White, G. H. Wood & Company Limited, representing local and national sanitation supply houses. Some of the many interesting discussions that took place on questions directed at the panel were: What is the major problem of the sanitation industry? Is competition in the industry too close? Do purchasers of sanitation products prefer to buy from more than one company?

Interested persons should address enquiries to any of the following executive members: president, Stanley J. McKenzie, Thomas Gibson & Company Limited, Scarborough, Ontario; vice-president, John C. Decker, H. S. Hunnisett Limited, Toronto, Ontario; secretary, Charles B. Hamilton, Fred Hamilton Sales Limited, Toronto, Ontario; treasurer, James L. Peterman, Peterman Products, London, Ontario; recording secretary, Jack V. Jacobson, G. H. Wood & Company Limited, Toronto, Ontario; membership chairman, Gordon D. Hay, G. A. MacEachern Limited, Toronto, Ontario; publicity chairman, Harold L. White, G. H. Wood & Company Limited, Toronto, Ontario.

New Beatty High Production Deep Fat Fryer

This new 12 kw. model DF20-3 electric deep fat fryer meets the requirements of modern high production frying, and requires less floor area than previous fryers. It is comparable in production to the model it supersedes yet requires 46 per cent less fat to operate, thus considerably reducing the cost of operation.

Features include new "swing out" elements similar in design to those used on smaller fryers made by same manufacturer, easily drained removable tank with filter drain-off located at front of fryer, twin thermostat control for maximum convenience and safety. Twin baskets are standard equipment as well as drain off tank located in lower compartment.

Floor area required is 20" wide

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x 31" deep. Unit is made for use on 230 volts single or 3 phase or 208 volts single or 3 phase. Three 4,000 watt elements allow balance of load on 3 phase circuits.

A companion fryer Model DF20-4 similar in all operating respects to the above but made with larger body to match standard ranges is also available.

For further details write to The James Stewart Manufacturing Company Limited, Penetanguishene, Ontario.

Deseret "Intracath" Added to C. R. Bard Line

C. R. Bard, Inc., has announced their appointment as exclusive distributors of the Deseret "Intracath" by the Deseret Pharmaceutical Company of Salt Lake City, Utah. Sales of the product will, of course, be through dealers only, in keeping with Bard policy.

To be known as the "Bardic Deseret Intracath", the device is an ingeniously designed intravenous catheter placement unit that greatly simplifies intravenous therapy, according to Bard. Packaged sterile and ready for use, the Intracath unit consists of a soft, pliant plastic catheter placed within the lumen of an intravenous needle. The venipuncture is made with this needle, and the Intracath is advanced through the needle approximately two inches into the vein. The technician then withdraws the needle, leaving the Intracath in position in the vein. The flared proximal end of the Intracath seats snugly into hub of the needle as the needle is withdrawn. The needle then becomes an adapter for any intravenous therapy set.

The Bardic Deseret Intracath, being a complete, sterile unit, does away with scrubbing and gloving; simplifies preparation and saves the hospital the expense of many hours of attendant care. This entirely new concept in method of intravenous therapy has been thoroughly tested and approved, through thousands of units placed into use.

Catalogue Issued on O. E. M. Equipment

Anew 36 page catalogue has just been published by the O.E.M. Corporation, East Norwalk, Conn. It is packed with detailed information regarding the full line of oxygen therapy equipment manufactured by the company.

Featured in the catalogue are five new oxygen tents developed by O.E.M.; the new Mechanaire, new automatic Mechanaire, high humidity Mechanaire and Mechanette and the new Mechanette. Eight pages are devoted to detailed descriptions of these versatile units that have given new impetus to the therapeutic use of the oxygen tent.

Write the O.E.M. Corporation, 5 Fitch Street, East Norwalk, Conn., for additional information.

Men are vain, but they won't mind women's working so long as they get smaller salaries for the same jobs.—*Cobb.*